ALBERTA WORKERS' COMPENSATION SYSTEM

MEDICAL AND APPEALS PERFORMANCE REVIEW

Report to The Minister of Labour & Immigration: Streamlining Medical Review and Appeals

Report by:

EngageFirst
Management Consultants

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Notice

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Executive Summary

A. Context

The Alberta Workers' Compensation System (WCS) has been reviewed at various points in time over the past twenty years. A focused review of the appeals and decision review system was conducted by a Review Committee appointed by the Minister responsible for the Workers' Compensation Board (WCB) in the year 2000. The committee recommended several substantive changes to the decision review and appeals process. Those recommendations informed the creation of new and changed structures which, for the most part, exists today.

The last major review of the WCS in Alberta was completed in 2017. It culminated in substantial changes in the system that were introduced in 2018. The most significant changes introduced in the appeal and medical review processes were the creation of an independent Fair Practices Office (FPO), an independent Medical Panels Office (MPO), and the new Employer Appeals Advisor service. In December 2020, the Government of Alberta passed the *Ensuring Safety and Cutting Red Tape Act 2020* (Bill 47) which restructured and moved the medical panel, fairness review, and appeals advisor services within the Workers' Compensation System. The WCB has created a Fairness Review function, and the Appeals Commission (AC) is administering the Appeals Advisor and the Medical Panel services. The FPO and the MPO offices were discontinued, however most of their services continue to be available. These changes were effective April 1, 2021.

The review was conducted at a time when significant changes resulting from new legislation were occurring in the WCS. At the time of writing this report, the Appeals Commission was in the process of re-organizing the Appeals Advisor and the Medical Panel services within its structure. Many of the relevant details were not clear at the time, and therefore may have changed after this report was completed.

B. Review Objectives

In January 2021, the Minister of Labour and Immigration appointed Engage First Management Consultants to conduct a performance review of the medical review and appeals services in the Alberta WCS, including the WCB and the AC. The project, the "Workers' Compensation System – Medical and Appeals Performance Review" (WCS-MAPR), would assess the need, appropriateness, effectiveness, and efficiency of the medical review and appeals services and make recommendations on how to strengthen and streamline them. The objectives were to identify opportunities throughout the medical and appeals system to:

- simplify the processes;
- streamline and reduce variance for WCB claims processes that require a medical review or appeal to ensure simplicity, avoid red tape, and minimize the time and cost to resolve them;
- identify opportunities to increase the responsiveness of the system to worker and employer needs through early resolution or intervention; and
- ensure long-term system sustainability.

C. Review Approach

The medical review and appeals processes within the WCS are known to be complex, and a thorough but pragmatic system-wide review approach was needed to complete the review. Leveraging prior knowledge of the system, a focused fact-finding and investigation plan was adopted to achieve new insights into the medical and appeals processes.

i. Information Gathering

Extensive information gathering was conducted which included the following methods.

- *Document Review* – Significant time was invested in collecting operational data, and reviewing documents that were requested from the system agencies, and from online information sources. A thorough review of this information revealed operational insights, and provided a foundation for further enquiries in the areas of interest.
- *Jurisdictional Scan* - A wide-ranging jurisdictional scan, which included interviews and document reviews, was undertaken of four provincial systems (WorkSafe BC, WCB Saskatchewan, WCB Manitoba, and WSIB Ontario) to gather comparative data related to each dimension of the evaluation. The extent of data that was gathered from the provincial systems provided meaningful comparatives and references.
- *Informational Interviews* - More than twenty-five system stakeholders, including management and staff of the system agencies, were consulted. Interviews were conducted with the leadership of key stakeholder organizations as well as with medical and appeals operational staff in all the system agencies to gather detailed information to help contextualize and better understand the evidence collected from the other methods. The latter group included Worker and Employer Appeals Advisors, WCB CSD Supervisors, and representatives from WCB DRDRB and Quality Assurance teams. Private advocates were also interviewed.

- *Analysis and Synthesis* - Achieving the objectives of the review required extensive analysis of the data gathered to gain a deeper understanding of the issues and concerns identified and uncovered. Once analyzed, the information was synthesized into common themes so that concrete recommendations could be made.

D. Our Findings

i. Overall

Alberta has the fourth largest WCS in the country with approximately 1.9 million worker's insured through 159,000 employers. The WCB processed approximately 130,000 new claims in 2019 of which just over 2% of decisions made by the WCB were disputed by a worker or an employer. A detailed mechanism for resolving disputes exists within the WCS starting with a negotiated resolution (within the WCB) followed by a formal and arbitrated final decision (outside of the WCB).

Workers generally request a review when they disagree with a WCB decision related to claim acceptance, entitlement, benefit, or fitness to work. Employers most commonly request a review when they disagree with a decision related to a worker's claim or with a decision related to an assessment on their account. The process for resolving these disputes starts with an informal negotiation with the Claim Owner who made the original decision. The Claim Owner may consult with their Supervisor to resolve the dispute. If resolution is not achieved, the dispute is referred to the WCB DRDRB, and finally to the AC if the previous approaches do not resolve the dispute.

The medical process may involve a Medical Consultant (MC) who provides medical opinions based on a review of the worker's medical file, or an Independent Medical Examiner (IME) who provides medical opinion based on a physical examination of the worker. The Medical Panel (MP) is a panel of health specialists who make final and binding decisions on medical matters to resolve differences in medical opinions of a very complex nature. All these processes help the Claim Owner in making an adjudication decision.

Alberta's WCS has been affected by the economic downturn from the Covid-19 pandemic. Compared to 2019, the system experienced a 9% decrease in the number of workers insured, and a 17% decrease in the number of new claims in 2020. However, the number of lost time claims, and the number of requests for review remained unchanged at about 30,000 and 2,200 respectively during the same time period. We are uncertain of what the post-pandemic future will look like, but out of an abundance of caution we relied on 2019-20 operational data for our analysis in this review.

For the most part, the system works well for the workers and employers. That being said, there are opportunities in the medical and appeals processes that, when leveraged, can improve the experience of workers and employers who disagree with a WCB decision. These findings generally fall under function, governance, and process categories as reflected by the chapter headings of this report.

ii. Specific Observations and Findings

In this section we present the facts and figures collected in our information gathering. These points do not purport to represent the whole picture. Further details can be found in the relevant chapters of this report.

Findings from Stakeholder Engagement

- Stakeholders from both workers and employers were satisfied that the system allows workers and employers multiple opportunities to request a review when they disagree with a decision made by the WCB.
- Claim Owners have a very challenging role as adjudicators, since claims are becoming more complex, and they must balance between the injured worker/employer interests, and WCB policies on entitlements and benefits.
- Based on Appeals Advisor's experience, a proportion of disagreements arise due to the worker or employer's inability to understand the decision letter, which can sometimes be complex, or lack clarity.
- Disagreements also arise due to perceived deficiencies in the quality of adjudication i.e. weighing of medical and non-medical evidence.
- There were mixed opinions about the quality of adjudication and dispute resolution by Claim Owners.
- Several stakeholders expressed lack of confidence in the DRDRB's review process. Most external stakeholders, including those among employers, would like to see changes made to the DRDRB decision review process to improve transparency and independence.
- Stakeholders have a healthy level of trust and confidence in the processes and decisions made by the Appeals Commission. Most stakeholders felt that the decisions made by the AC are fair and independent.
- Most stakeholders would like the Medical Panels to continue because it serves a very unique and a needed purpose in the system.
- The system funded Appeals Advisors enjoy a good reputation among all stakeholders. Some stakeholders suggested involving advisors earlier in the process, especially for vulnerable clients, to mitigate the risk of disagreements escalating into disputes.

- In the experience of WCB staff, the resolution process and negotiation with private advocates does not have the same professionalism and efficiency as with the system funded Appeals Advisors.
- The most common concern regarding the entire medical review and appeals process was the length of time it took at every step of the process. Stakeholders were concerned about the lack of adherence to service standards for completion of processes.

Findings from Operational Data Analysis of Alberta WCS (based on 2019 data)

- Approximately 2% (2738) of the total new claims had a disagreement or a dispute, of which about 33% were resolved by the Claim Owner, and the remaining were referred to the DRDRB within 14 days.
- The DRDRB's Resolution Specialists (15.5 FTE's) reviewed 1,836 DRDRB cases, averaging 118 reviews completed per Specialist per year.
- Approximately 88% of DRDRB reviews were completed within their service standard of 40 days. This does not include days lost due to postponement (requested by the claimant). About 55% of the cases were postponed by an average of over 100 days.
- The DRDRB upheld 80% of the Claim Owner's decisions, and the remainder were reversed or varied.
- A decision review by the DRDRB costs about $1,035 per case.
- The AC decided on 507 appeals, at an estimated average cost of about $13,262 per hearing (based on total AC budget). Some cases may require more than one hearing.
- The AC confirmed 56% of decisions made by the DRDRB, reversed 24%, and varied 20% of them.
- An AC appeal required about 209 days from intake to decision compared to their target of 180 days. When delays from postponement (at the request of a party to the dispute) or adjournment (decided by the Chair during the hearing) are included, the average duration from intake to decision is about 100 days more.
- There were 20,857 referrals to Medical Consultants, which is about 27% of total claims in active case management (Note: claims in active case management include new time lost claims plus claims open from previous years. Based on the Medical Consultants' Quality Assurance Report of 2019 about 44% of medical consultations are related to claims that started in the same year, of these just under 1% are related to no time lost claims. In some instances where a no-time lost claim requires an MC, it may be accompanied by a change in status to time lost claim. Hence, although no time lost claims may require an MC, comparison of medical consultations using active claims is more realistic.)
- An MC referral costs an average of $144 per referral and requires about 4 days to complete.

- There were 1,417 IMEs, which is about 2% of total claims in active case management (new time lost plus open from previous years).
- An IME costs an average of $1,614 and requires about 42 days on average.
- There were 13 Medical Panels in 2019 at a cost of $20,152 per panel. On average a panel required 411 (Appendix 13) days from intake to decision (includes MP requests that were in the backlog).
- About 55% of injured workers and employers chose to be represented by an Appeals Advisor in the AC, 40% were represented by private advocates and the remaining 5% were self-represented. The Appeals Advisors were successful in reversing or varying 45% of the decisions, compared to private advocates and self-represented who had a 35% success rate.

Findings from Jurisdictional Scan

- Workers and employers in Alberta have one year to submit a request for review to the WCB, while in BC the limit is 75 days, SK and MB have no time limit, and in ON the time limit is 30 days for return-work-decisions and 6 months for other decisions.
- Alberta's review body (DRDRB) upholds 80% of the decisions made by the Claim Owner, which is higher than in any of the other provinces (BC-60%, ON-72%, SK and MB 75%).
- Alberta is the only jurisdiction in which the review body has a participative approach with the Claim Owner during the review. In other jurisdictions, the review is done independent of the Claim Owner.
- SK is the only jurisdiction where the appeal tribunal is not external to the WCB.
- The proportion of requests for review that get escalated to the Appeals Commission (tribunals) in Alberta is 28%, which in absolute numbers is higher than in other provinces where the ratio is between 16% to 25%, notwithstanding the differences that exist between the systems.
- AB and MB hold more in-person hearings at 75% and 86% respectively at the tribunal/appeal level, compared to BC (38%) and ON (32%). BC and ON have higher proportion of documents-only hearings at appeal.
- AB has a higher proportion (44%) of Review Body decisions reversed or varied at the tribunal/appeal level, compared to BC and MB where the tribunal reverses or varies 30% and 37% of decisions respectively.
- The timing and type of medical consultations done by the Claim Owner varies from one WCB to another. BC has a time bound threshold for escalating the medical file, Alberta does not.

- Alberta has the lowest ratio of referrals to Medical Consultants (27%) per active case management file (new lost time claims plus claims open from previous years) compared to the other provinces e.g. BC (64%).
- AB has Independent Medical Examiners and other provinces have similar services available for expert medical opinions. MB allows medical advisors to perform physical examinations if needed, BC has independent physicians that may examine the worker, and in SK and ON a multidisciplinary assessment may be used to provide expert medical opinion. Multi-disciplinary assessments are also available in Alberta for fitness for work, or treatment needs.
- The proportion of IMEs to files in case management (new lost time claims plus claims open from previous years) is lower in Alberta (2%) compared to SK (12%) and MB (16%) but higher than BC (1%).
- ON has a Medical Liaison Office which helps prevent medical disputes by conducting medical file reviews on cases with medical complexities prior to the appeal.
- AB, SK, and MB have Medical Panels or equivalent, though their function and process varies. A medical panel (or equivalent) may be requested at any time in the dispute process in AB and MB. In SK they can only be requested after the final level of appeal and only by a worker.
- The number of medical panels in AB, SK, and MB are very small (below 15 per year) indicating the highly specialized nature of the panel. BC and ON do not have an equivalent body.
- All the jurisdictions have system funded appeal advisors for workers. AB, BC, and ON also have appeals advisors for employers.
- Alberta is the only province where the system funded appeals advisors are administered by the Appeals Commission which is within the system. In all other provinces they are part of a provincial ministry, therefore outside the system.
- ON requires private advocates to be certified by the provincial law society. No other province has any professional or regulatory requirements for the private advocates.

E. Recommendations

Based on a thorough analysis of the facts and evidence gathered for this review we have made 22 recommendations. Our recommendations attempt to address the issues that stakeholders have been experiencing in the medical review and appeals processes. A list of impacts on key stakeholders and on the system is available in the implementation section of this report. In addition to the recommendations, throughout this report there are many additional opportunities worthy of consideration, as well as examples of practices in other jurisdictions worth adopting.

Our analysis indicates that the cumulative impact of the recommendations will be a 15-30% reduction in referrals to DRDRB, AC, Medical Consultant, and IME. In addition, the report identifies opportunities for reducing the process durations in DRDRB, AC, and MP by about 60-100 days. Financial analysis indicates that when implemented, the recommendations could deliver savings of approximately $3.0 million per year for the system. This translates to quantifiable net savings of about $10 million in present value terms over the next five years. These savings do not include the intangible benefits that would be realized from qualitative improvements in the processes and in the experience of the stakeholders. The decrease in waiting time will also have economic benefits by facilitating earlier return to work for hundreds of injured workers, but are difficult to estimate.

The critical success factor for realizing the benefits depends on successfully aligning and improving the upstream processes i.e. adjudication decision and communication, medical consultant referrals, and DRDRB decision review. Implementing the recommended changes will require executive intent and willingness to make the changes. Commitment from the leadership of the WCB and the AC will be critical for success.

The recommendations, when implemented, will improve the experience of all the system stakeholders including those who deliver these services. The implementation of these recommendations should be grounded in the principle that the quality of experience during dispute resolution measured in fairness, transparency, efficiency, and timeliness needs to be improved. While operational and policy improvements will bring about the initial change, long-term success will depend on sustaining the recommended changes.

Alberta's WCS is among the better performing workers' compensation systems in Canada based on the metrics that are reported by all provincial systems. With the recommended changes Alberta will clearly demonstrate its commitment to improving the experience of those workers and employers who are not satisfied with WCB's decisions, and to providing them a better chance to amends as needed.

i. Summary of Recommendations

#	Recommendation	Page #	Lead	Highest Level of Required Change		
				Legislation	Policy	Operations
1	Clearly define the nature of the statutory decision review including the authority and accountability of the Review Body referred to in WCA section 9.3/9.4.	51	WCB		√	
2	Require an independent review of the medical file when a medical dispute remains unresolved and determine an appropriate timing of this review.	58	WCB		√	
3	Continue risk assessment and strategies to mitigate potential challenges emerging from the reorganization of the Appeals Advisors with the Appeals Commission.	61	AC			√
4	Facilitate sharing of relevant worker data, under appropriate assurances, which the Employer Appeal Advisors are entitled to for conducting their statutory responsibilities.	64	WCB		√	
5	a) Create an information strategy that supports alignment in data definition and data capture for better performance management of medical and appeals processes across system agencies.	67	WCB			√
	b) Create reporting standards with common indicators and measurements for reporting the operational performance of decision review and appeals seamlessly among system agencies.		WCB			√
6	a) Strengthen the quality control and quality assurance practices for all key determinants of process outcome such as: MC memo, adjudication decision letter, DRDRB hearing and decision making, AC information package and hearing, MP hearing, and AA initial review and representation.	72	WCB, AC			√
	b) The Workers' Compensation System report annually on analysis of trends for disputed decisions and the quality assurance of decision-making processes from adjudication to appeals.		WCB, AC			√
7	a) Revise the decision letter template to include information about supports available for workers and employers seeking clarification or dispute resolution.	82	WCB			√
	b) Enhance the quality control of decision letters before they are sent out.		WCB			√

#	Recommendation	Page #	Lead	Highest Level of Required Change		
				Legislation	Policy	Operations
	c) Enhance the assurance audit of decision letters to include factors that improve the communication value of the letter, in alignment with the decision letter style guide.		WCB			√
	d) Adopt a continuous improvement approach to decision writing skills with feedback and re-training.		WCB			√
8	Redefine the role of the system funded Appeals Advisor to extend their advisory role in the early stages of dispute i.e. disagreement with the decision letter.	84	AC		√	
9	Structure the 30-day duration for CSD resolution and implementation to be utilized in value adding collaborative actions.	86	WCB			√
10	a) Address the issues that cause high rates of postponement in the DRDRB, and target to eliminate postponement occurring due to avoidable reasons.	90	WCB			√
	b) Report the actual days for completion of reviews to reflect the real-life experience of workers and employers, and manage performance based on that metric.		WCB			√
11	a) Define a clear governance and organizational model for the DRDRB to create an independent and arms-length operation from CSD. Delink the DRDRB role from any quality assurance or learning outcomes for CSD.	92	WCB		√	
	b) Redefine the decision-making model of the DRDRB to better align with expectations of a statutory decision review.		WCB		√	
12	Clarify the interpretation and application of policies where there are frequent differences between the Claim Owner, DRDRB, and AC decisions based on analysis of trends.	96	WCB			√
13	Review the practice of DRDRB sending back a case for re-adjudication when new evidence is related to a decision in dispute.	98	WCB			√
14	a) The AC take appropriate steps to reduce the time between intake and hearing date, and between hearing and decision date for appeals that have fewer or less complex issues, to within service standards.	102	AC			√
	b) The AC address the issues that cause high rates of postponement. Target to eliminate		AC			√

#	Recommendation	Page #	Lead	Highest Level of Required Change		
				Legislation	Policy	Operations
	postponement (or adjournment) occurring due to avoidable reasons.					
	c) The AC report the average duration for each type of appeal so the duration reflects the real experience of appellants.		AC			√
15	Facilitate one to one follow up between the Treating Physician and the Claim Owner, with the support of a medical professional, when only a clarification or additional information on a medical opinion is needed.	115	WCB		√	
16	Require a mandatory contact between the Treating Physician and the Medical Consultant when the Medical Consultant is providing a medical opinion that is different from that of the Treating Physician.	119	WCB		√	
17	a) Update Medical Consultant memo audit tool to include factors that improve quality of process such as completion of contact with the Treating Physician, and information sharing with Treating Physician.	122	WCB			√
	b) Review the service standards and incentive plan for the Medical Consultant to improve balance in incentives for timeliness, quality of process, and quality of output.		WCB			√
18	a) Allow the Appeal Commission to consult a medical professional when framing questions for a Medical Panel.	128	AC		√	
	b) Allow the Medical Panel to clarify a medical question before the hearing.		AC		√	
19	Streamline the Medical Panel selection process by removing the option given to the worker, employer and the WCB for choosing a Medical Panel member. Allow the MPC to appoint the Medical Panel from the eligibility list.	130	L&I	√		
20	Make selection of Medical Panel members and hearing date easier and faster by using enabling technology.	131	AC			√
21	a) Continue the Employer Appeals Advisor service and rationalize services between the Employer Advisors Branch (EAB) and the Employer Appeals Consulting (EAC) service to reduce duplication.	139	WCB, AC			√
	b) Improve awareness among stakeholders of the availability of the Appeals Advisor service through better communication and promotion.		AC			√

1. Review Context and Approach

1.1 Introduction

The Workers' Compensation System (WCS) in Alberta consists of the Workers' Compensation Board (WCB) and the Appeals Commission (AC). The WCB administers Alberta's workers' compensation system by providing insurance for workplace injury and illness for workers and employers in an employer-funded model. The WCB provides insurance coverage to Albertans through their employers, and provides workers with compensation, treatment, training and supports needed for their successful rehabilitation and return to work following a work-related illness or injury. The AC consists of the appeals tribunal and the Medical Panel (MP) which are the final decision makers for claims and medical disputes respectively, and the Advisors Office (AO) which provides advice and representation to workers and employers in the dispute resolution process.

The Alberta WCS has been reviewed at various points in time over the past twenty years. A focused review of the appeals system was conducted in the year 2000 by a Review Committee appointed by the Minister responsible for the WCB. The committee recommended several substantive changes to the decision review and appeals process, creating new, or changing the structures that existed at the time, to what exists today for the most part. These recommendations were based on the findings of an extensive survey to which more than five hundred stakeholders had responded. The findings from the survey were indicative of the operational performance of the system that existed in the year 2000. For example, 76% of respondents indicated that it took them 3 to 9 months to get the initial review done by the Customer Services Division (CSD) Manager, and 64% respondents indicated it took 3 to 9 months to get the first level decision review done by the Claims Services Review Committee (CSRC), which was a precursor to the present-day Dispute Resolution and Review Body (DRDRB). Only 22% indicated they received a decision from the CSRC that was acceptable to them. Among those who had experience with the Appeals Commission, 60% indicated their appeal was decided within 6 months, and 41% indicated they had utilized the services of a government funded Appeals Advisor (AA) for representation and advice. As this report will show, the situation is not much different in the present time.

The last major review of the entire WCS in Alberta was completed in 2017. It culminated in substantial changes to the system that were introduced in January 2018. The most significant changes introduced in the appeals and medical processes were the creation of an independent Fair Practices Office (FPO), an independent Medical Panels Office (MPO), the Employer Appeals Advisor service, and extending the time

period for filing second level appeals to two years. Some of these and other changes were later challenged by stakeholders due to their impact on the sustainability of the system due to additional costs and administrative burden to employers. The government undertook a targeted stakeholder engagement in summer 2020 to review the *Worker's Compensation Act* (WCA). A separate program review of the FPO and MPO was also completed in alignment with government's review of agencies, boards, and commissions.

In December 2020, the Government of Alberta passed the *Ensuring Safety and Cutting Red Tape Act* (Bill 47) which restructured and moved the medical panel, fairness review, and appeals advisor functions within the Workers' Compensation System. The FPO and the MPO offices were discontinued, however most of their services continue to be available. The WCB has created a Fairness Review function, and the Appeals Commission is administering the Appeals Advisor and the MP's function. These changes were effective April 1, 2021.

This performance review also comes at a time when red tape reduction and process efficiency in the public sector are in sharp focus. The Government of Alberta adopted the *Red Tape Reduction Act* in 2019. The Act recognizes that some regulatory and administrative requirements result in unnecessary costs for Albertans in terms of time, money, or other resources, and should be reduced. To address these challenges, the government committed to eliminating and preventing unnecessary regulatory and administrative requirements by establishing strategies and initiatives based on the principles of necessity, effectiveness, efficiency, and proportionality. This included moving from a process-based to an outcome-based regulatory approach. These principles will provide important guidance in our evaluation of the medical review and appeals processes.

The review was conducted at a time when significant changes resulting from the new legislation were occurring in the WCS. At the time of writing this report, the Appeals Commission was in the process of re-organizing the Appeals Advisor and the Medical Panel services within its structure. Many of the relevant details were not clear at the time, and therefore may have changed after this report was completed.

The Covid-19 pandemic hit the province of Alberta in March 2020. These are unique times from which, like all businesses, the workers' compensation system has been affected. Our data collection covered the last few years, including the time-period since the pandemic started. Early analysis indicated a difference in the operational volumes for pre-Covid-19 years and the last year when the pandemic was at its worst. There is universal acceptance that services have had to adjust and align with the new normal that is still

evolving. To avoid any misguidance, we decided not to reference the pandemic year (2020) dataset, we have instead used 2019-20 as the reference year for our analysis.

As we write this report, we are still in the midst of the pandemic, and it is impossible to foresee what the post-Covid-19 reality might look like. This report does not speculate a future state in the post-pandemic era and should be read in the context of the services as they exist at the time of writing the report.

1.2 The Review

Alberta's WCB is the fourth largest workers' compensation system in the country with approximately 1.9 million worker's insured through 159,000 employers. The WCB processes approximately 130,000 new claims each year in which just over 2% of decisions are disputed by a worker or an employer. There exists a detailed mechanism for resolving disputes with an alternate dispute resolution (ADR) approach first, and an arbitrated final and binding decision as a last option.

In January 2021, the Minister of Alberta Labour and Immigration contracted with Engage First Management Consultants (EngageFirst) to complete a performance review of the medical review and appeals processes of the Workers' Compensation System. The "Workers' Compensation System – Medical and Appeals Performance Review" (WCS-MAPR) would assess the need, appropriateness, effectiveness, and efficiency of the medical and appeals services and make recommendations on how to strengthen and streamline them.

EngageFirst approached the review with an overall goal of creating a balance between the need to deliver efficient and timely decisions, and the need for adherence to the principles of administrative justice. The primary objective of this review was to make actionable recommendations that may include changes to the methods of resolution, systems, processes, and procedures for WCS's medical review and appeals services to make them:

- more responsive to the needs of the stakeholders,
- more streamlined, and
- more efficient and effective in achieving the desired outcomes for stakeholders.

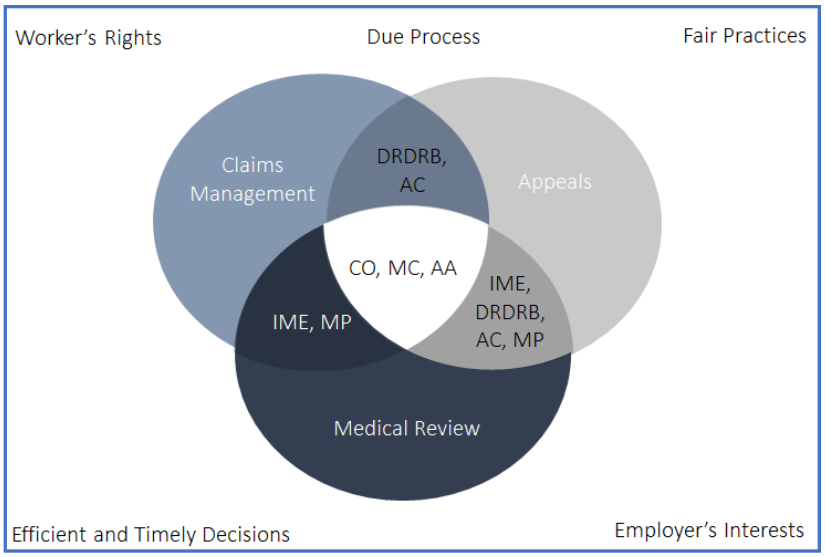
The review was designed to identify opportunities throughout the medical and appeals system to:

- simplify the processes;

- streamline and reduce variance for WCB claims process that require a medical review or appeal to ensure simplicity, avoid red tape, and minimize the time and cost to resolve them;
- identify opportunities to increase the responsiveness of the system to worker and employer needs through early resolution or intervention; and
- ensure long-term system sustainability.

1.3 Review Approach

Alberta workers' compensation medical and appeals process is complex, and for the most part it is intertwined with the claim management process. As seen in the figure on the next page, there are multiple roles and stakeholders in the system with varied interests who together make for a dynamic environment. To complete the review in the most efficient way, we had to be pragmatic based on where the most impactful changes could be made. We created a set of guiding principles (Appendix 6) to keep us focused, and adopted a targeted fact-finding and investigation approach, leveraging our prior knowledge of the system to achieve a new level of insight into the medical and appeals processes. Information gathering was the most critical part. Through probing and analysis we were able to zero-in on the real opportunities for enhancement in the system, that are reflected in the recommendations.



Note: WCB Claim Owners are the recipient of all medical/appeal decisions and advice in the process.
Please refer to the glossary of terms for abbreviations.

Figure 1.1: WCS-MAPR Review Framework

Document Review

We conducted an extensive exercise for collecting operational data, reviewing documents that were requested from the system agencies, and from online information sources. The information included legislation, mandates, policies and procedures, job descriptions, annual reports, performance and accountability reports, and operational data. A thorough review of this information gave us operational insights, and provided a foundation for further enquiries in the areas of interest.

Jurisdictional Scan

A wide-ranging jurisdictional scan was undertaken of four provincial systems (WorkSafe BC, WCB Saskatchewan, WCB Manitoba, and WSIB Ontario) to gather comparative data related to each dimension of the evaluation. Information collection included over a dozen conversations with key personnel in all the jurisdictions. The extent of data that we gathered from the provincial systems provided meaningful comparatives and references.

Informational Interviews

More than twenty-five system stakeholders, including management and staff of the system agencies, were consulted through interviews and email communications. We conducted interviews with the leadership of key stakeholder organizations including the Ministry of Labour and Immigration, system agencies, representative associations for employers and workers, advocates, and the Alberta Ombudsman. Interviews were also conducted with medical and appeal operational and delivery staff in all the system agencies to gather detailed information to help contextualize and better understand the evidence collected from the other methods. The latter group included Worker and Employer Appeals Advisors, WCB CSD Supervisors, representatives from WCB DRDRB and Quality Assurance teams. Private advocates were also interviewed.

Analysis and Synthesis

Achieving the objectives of the review required a strategic and incremental approach to analyzing the data gathered. The first stage analysis created a clear picture of the current state through data tabulations, process models, value maps, and other representations to identify process deficiencies and opportunities. The second stage analysis involved more refinement and focus through the benchmarking and comparison of performance indicators both at a process level and program/organizational level. The final step was to

identify the most impactful opportunities and how to address them through the proposed recommendations.

1.4 The Report

A brief description of each section in this report is provided below. For further clarity, our recommendations are delineated in plain text boxes, and comparable information from other provincial systems are in shaded text boxes.

Review Context and Approach – this chapter provides a background for the review including the objectives and review approach.

Regulatory Framework – lists the relevant acts and regulations, and summarizes the significant changes in legislation relative to the medical review and appeals process that have come into effect since April 2021.

Medical Review and Appeal in Provincial WCBs – describes in detail each of the four jurisdictions that were studied and compared.

Dispute Resolution Principles and Practices – provides a framework for principles, models, and best practices in dispute resolution that are universally applicable and also relevant to workers compensation.

Medical Review and Appeal in Alberta - A System Perspective – provides an organizational and system perspective of the medical review and appeals mechanism in Alberta WCS, identifies opportunities, and provides recommendations.

Dispute Resolution and Appeal - A Process Perspective – traces the path of a claim related dispute through the dispute resolution process in Alberta WCS, identifies opportunities, and provides recommendations.

Medical Opinion and Medical Panel - A Process Perspective – traces the path of a medical disagreement or dispute through the dispute resolution process in Alberta WCS, identifies opportunities, and provides recommendations.

The Appeal Advisor – describes the service and provides recommendations related to the appeals advisor service funded by the system and other options for advice and representation available to workers and employers in Alberta.

Implementation and Change Management – provides clear direction for next steps and the path forward for implementing the recommendations of this report, as well as a summary of impacts on stakeholders.

Summary of Recommendations – lists the recommendations and provides the implications for legislation, policy and operations based on each recommendation.

Glossary of Terms –available in Appendix 1, provides a list of terms and acronyms used in this report.

Appendix – includes supporting information and references.

2. Regulatory Framework

2.1 Legislation

The WCA creates the Workers' Compensation Board and grants it authority to administer a system for providing insurance for workplace injury and illness for the workers and employers. Alberta's workers' compensation system operates under a complex set of legislative and regulatory authorities. The enabling Acts and Regulations include:

i) *Workers' Compensation Act,*
ii) *Occupational Health and Safety Act,*
iii) Workers' Compensation Regulation,
iv) Firefighters' Primary Site Cancer Regulation, and
v) Medical Panels Regulation

The following Acts and related regulations are relevant to the medical and appeals functions within Alberta's workers' compensation system:

vi) *Alberta Human Rights Act,*
vii) *Alberta Public Agencies Governance Act,*
viii) Alb*erta Freedom of Information and Protection of Privacy Act,*
ix) *Alberta Government Accountability Act,*
x) *Alberta Health Information Act,*
xi) *Alberta Ombudsman Act, and*
xii) *Canada Health Act*

In addition to the above laws and regulations, the WCB has a comprehensive Operational Policy and Information Manual which sets out the foundational principles and policies that govern its system administration mandate. The Appeals Commission for Alberta Workers' Compensation has Rules and Practice Guidelines and Appeals Rules which apply to the appeals tribunal function. Likewise, there are General Rules of Procedure which apply to the medical panels. Except for the Medical Panels General Rules of Procedure, all other laws, regulations, policies, and guidelines are available online for public access.

2.2 Amendments to the Workers Compensation Act

The *Ensuring Safety and Cutting Red Tape Act* 2020 (Bill 47) was passed by the Alberta legislature in December 2020 to implement changes based on a targeted stakeholder engagement process and reviews of the FPO and the MPO. Bill 47 authorized several amendments to the WCA and related regulations. The main changes in relation to medical and appeals in Alberta workers' compensation system were:

Obligation to Reinstate

The employer obligation to reinstate an injured worker was removed from the WCA. The duty to accommodate a disabled worker continues under human rights legislation. Employers have a duty to cooperate in an injured workers' early and safe return to work. In a reciprocal obligation, injured workers continue to have a duty to cooperate with rehabilitation plans.

Fairness Review Officer (FRO)

- A new role was created to handle fairness review matters in WCB. The FRO follows the established Code of Rights and Conduct under section 9.2(1), and reviews complaints related to fairness in procedure and treatment against any aspect of the WCB. The Fairness Process Review Centre will be administered by the WCB.
- Fairness review services will continue to be available free of charge to injured workers and employers. A fairness review officer reporting directly to the WCB Board will provide these services.

Fair Practices Office

- Ceased to exist effective April 1, 2021.

Review Body

- The Review Body provisions were clarified to reflect that review decisions related to compensation as well as employer assessments are handled by a single Review Body. The DRDRB handles both types of reviews.

Appeals Commission

- The time to appeal a decision from the internal WCB to the Appeals Commission review body was reduced from 2 years to 1 year as was the case prior to 2018.
- The AC was given an additional mandate to administer the MPs and the Appeals Advisor services.

- The role of AC Vice-Chair was added to the Workers' Compensation Act, and the role of temporary Appeals Commissioner was repealed. Term length of the AC Chair and Vice-Chair was increased from 3 years to 5 years.
- Some of the prescriptive elements of the AC's reconsideration of its own decision process were removed to reduce time and costs for workers' compensation agencies and other parties involved in the reconsideration request. Steps and requirements were outlined in a guideline document by the AC.

Appeals Advisor

- WCA authorizes the AC to continue the Appeals Advisor services providing independent advice, assistance, and advocacy services to employers and to workers which were previously provided by the FPO.

Medical Panels Office

- Ceased to exist effective April 1, 2021.

Medical Panels

- Now administered by the AC as a service to the AC, WCB, and worker.
- Case conferencing as a requirement has been removed from legislation but can still be utilized where it can be productive.

Independent Medical Exams

- Continues but the roster of qualified physicians is now maintained by the WCB.

3. Medical Review and Appeal in Provincial WCBs

3.1 Introduction

The jurisdictional scan conducted for the medical and appeals performance review included four provincial WCB systems: WorkSafe BC (WSBC), Saskatchewan WCB (SWCB), WCB Manitoba (WCBMB), and the Workplace Safety and Insurance Board of Ontario (WSIB). Information was collected through online research, interviews, and correspondence with personnel from these organizations. This section of the report contains a summary of key findings and comparison of best practices utilized in the provincial systems organized by dispute resolution process, followed by a summary of each provincial system. More detailed descriptions of each jurisdiction's system can be found in the Appendix 22, and high-level process maps are available in Appendix 21. The figure below shows the relative size of the provincial systems in relation to disputes and appeals. Further jurisdictional facts and data are embedded in topical sections throughout this report.

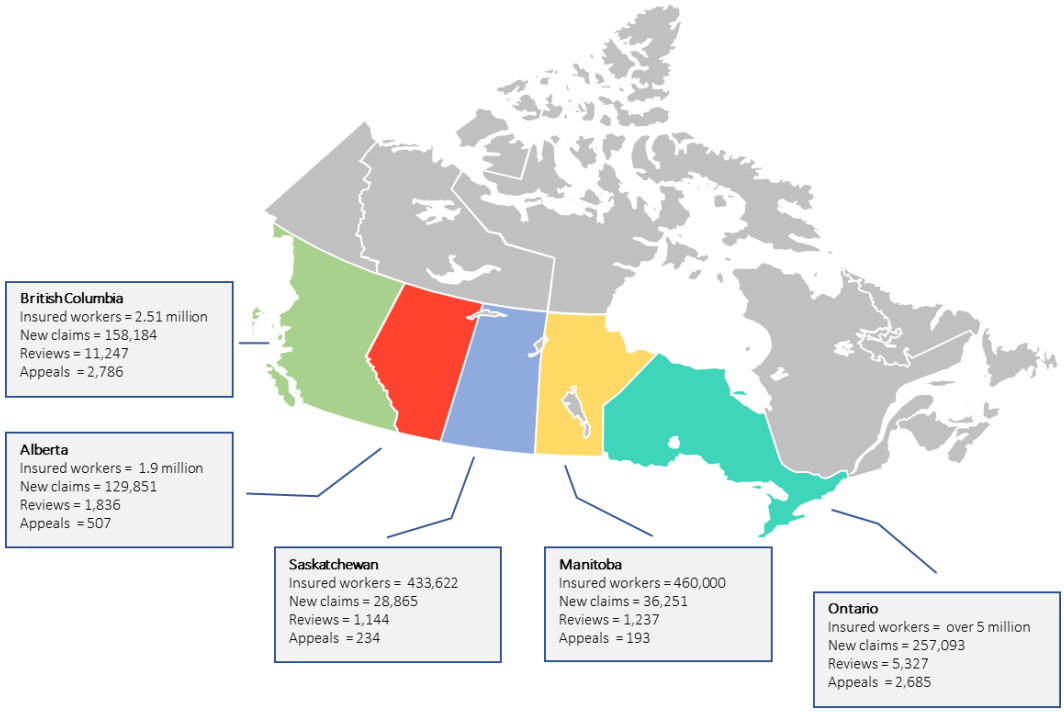


Figure 3.1: Provincial Workers' Compensation Systems

The table that follows provides an overview and comparison of the qualitative dimensions of the dispute resolution mechanism in the five provincial systems, including Alberta. It outlines the form, composition, function, and practices of the main dispute resolution bodies in each system.

System Comparison	AB	BC	SK	MB	ON
CLAIMS ADJUDICATION					
Claims Processing	Claim Owner / Adjudicator	Claim Owner or Manager	Case Manger	Case Manager	Decision-Maker
Time Limit for Reconsideration	No time limit	75 days	No time limit	No time limit	6 months or 30 days for RTW
INTERNAL REVIEW					
Review Body	DRDRB	Review Division	Appeals Department	Review Office	Appeals Services Division
Relation with Claims Processing	Participatory	Independent	Independent	Independent	Independent
Resolution Method	Alternate Dispute Resolution	Documentary	Documentary	Documentary	Oral or Documentary
Time Limit for Request by Claimant	1 year from decision	90 days from decision	No time limit	No time limit	No time limit once "Intent to Object" submitted
EXTERNAL/INTERNAL APPEAL					
Appeals Body	Appeals Commission	Workers' Comp. Appeal Tribunal	Board Appeal Tribunal	Appeal Commission	Workplace Safety and Insurance Appeals Tribunal
Internal or external to WCB	External	External	Internal	External	External
Appeals Process	Documentary or In-Person Hearing	Documentary or In-Person Hearing	Documentary or In-Person Hearing	Documentary or In-Person Hearing	Documentary or In-Person Hearing
Size of Appeal Panel	2-9 person panel (usually 3)	1–7-person panel	1–3-person panel	3-person panel	1–5-person panel
Time Limit	1 year from review decision	90 days of review decision	No time limit	No time limit	6 months of review decision
MEDICAL REVIEW					
Medical Consultant Function	Medical opinion	Medical opinion	Medical opinion	Medical opinion - can examine worker	Medical opinion
Employment	Full-time and part-time contractors	2/3 perm. f/t & 1/3 p/t contractors	1/2 perm. f/t & 1/2 p/t contractors	Part-time contractors	Part-time contractors
Contact and physical exam of worker	No	No	No	Communicates and examines	No
Communication with Treating Physician	Communication encouraged	Communication encouraged	Infrequent	Communication encouraged	May communicate
IME	Yes	No	No	Yes	No
Medical Panels	Yes	No	Yes	Yes	No
SYSTEM FUNDED ADVISOR/REPRESENTATIVES					
Government Funded Representatives	Worker and Employer Advisors	Worker and Employer Advisors	Worker Advisors	Worker Advisors	Worker and Employer Advisors

3.2 System Highlights

The high-level overview of the medical and appeals systems in AB, BC, SK, MB, and ON reveal comparable roles and processes. All jurisdictions have primary adjudicators similar to Alberta's WCB Claim Owners, who have access to Medical Consultants for opinions. Each jurisdiction also has two levels of review/appeal resolution bodies for employer and worker disputes. However, the organization of these dispute resolution bodies varies from one province to another. The most significant differences are in the medical dispute processes, as only one other jurisdiction has Independent Medical Examinations and two others have Medical Panels. While these differences are notable, each jurisdiction puts an emphasis on early resolution and prevention of claim and medical disputes through mechanisms similar to those utilized by Alberta.

Quality assurance (QA) of claim adjudication (i.e. quality of decisions and decision letters), and of decision making in the review and appeal stages, is another area that differs across the provinces. Depending on the size of the jurisdiction, the resources applied to QA varies. In Manitoba, QA can be completed by managers or directors of each department. While Manitoba sees significantly fewer claims per year than Alberta, they maintain a formalized QA process within claims adjudication and in their internal and external appeals bodies. They also share analysis of trends and statistics with the departments.

BC receives 19% more claims each year than Alberta and conducts a robust QA process. Claims adjudication and the Internal Review Division both investigate trends and perform internal audits that are utilized while designing staff training and informs policy review. Their external appeal office, Workers' Compensation Appeals Tribunal (WCAT) has a Tribunal Council Office that is responsible for similar QA monitoring. In addition, all QA personnel regularly meet to discuss quality issues seen in each department, looking for trends that would identify issues with legislation or policy that can be forwarded to the policy department. For example, recently their audit identified the need to re-evaluate how psychological injury claims were adjudicated.

3.3 Claims Dispute Process Highlights

Typically, as a first step of dispute resolution for claims, the claimant is encouraged to discuss how the adjudication was performed leading to a decision with the Claim Owner. In BC, this is optional, the claimant may go directly to the Review Division, while starting with the Claim Owner is a mandatory step in all other provinces. In ON, if the dispute is related to return to work (RTW), they may request a Return-to-Work Specialist be consulted to assist with mediation.

For disputes that are not resolved with the Claim Owner, each province has a review body that is internal to their WCB system. There are no time limits for requesting a review in SK or MB. In BC appellants have 90 days to request a review, and in ON they have 6 months (or 30 days for return-to-work disputes).

No other jurisdiction utilizes a model like Alberta where the Resolution Specialist (RS) meets with their supervisor, the Claim Owner, and the Claim Owner's Supervisor, in a participative approach to change a decision. Instead, each province's review body completes an entirely independent adjudication on the disputed issues. They do not speak with the Claim Owner unless they need to clarify something on the file. Reviewers in all jurisdictions may return a file to the Claim Owner if substantial new evidence is presented that would undoubtedly change their decision. Reviews are primarily documents-based in the jurisdictions, with options for formal and informal enquiries, except for ON which designates a documentary or oral hearing at intake.

All jurisdictions, except SK whose second level of appeal is internal, have external appeals bodies. BC, MB, and ON appeals are conducted similar to Alberta and are heard by panels of 1-3 members depending on the jurisdiction and type of claim. In BC non-precedent appeals can have panels of up to 7 members. While they all have documentary or oral hearings, whether the appellant can choose the format differs by jurisdiction. In BC, SK, and ON the appellant does not get a choice.

3.4 Medical Dispute Process Highlights

The role that Medical Consultants play in dispute resolution varies across provinces. In BC, MB, and ON, Medical Consultants are encouraged to contact the treating physician to help resolve differences in medical opinions. In BC, this contact is mandatory when a worker has been off for longer than eight weeks. In ON a return-to-work specialist becomes involved if the worker has been off-work for four weeks.

MB's system is quite unique. Over ten years ago, in response to a growing number of IMEs and MPs, they instituted a process where Medical Consultants were encouraged to speak with and physically examine an injured worker in order to give a more accurate medical opinion. This was found to significantly decrease the need for both IMEs and MPs, and now neither are required with any regularity. Despite this decreased demand (only one MP in the last three years) WCBMB allows IMEs and MPs to be requested to resolve disputes with medical complexities.

MB is the only other jurisdiction that offers IMEs. BC, SK, and ON do have some form of external medical assessment programs, but not quite the same as the IMEs. In a recent review by an external reviewer for WorkSafe BC, it was recommended they adopt an IME-type of process.

In addition to AB and MB, SK also has MPs. However, while a MP may be requested by any level in the dispute system in AB and MB, in SK they can only be requested after the final level of appeal when a medical claim was previously accepted and disagreements on the workers medical condition remain. Only the worker may initiate a request for MP in SK.

While ON does not have MPs, they do have a Medical Liaison Office (MLO) within their external appeal body, Workplace Safety and Insurance Appeals Tribunal (WSIAT), that is distinctive. The Medical Liaison Office helps prevent medical disputes by conducting medical file reviews on cases with medical complexities prior to the appeal, and they support medical adjudication by answering medical questions from adjudicators and occasionally arranging physical exams.

3.5 Appeals Advisor Services

All jurisdictions have system funded advisors and representatives for workers, while BC and ON (like Alberta) also offer them to employers. All advisor offices are located externally from WCB and appeals bodies (unlike Alberta). In BC, SK, and ON the system funded advisors are administered by the ministry responsible for workers' compensation, in MB by the Ministry of Finance and Regulatory Services, and in Alberta by the Appeals Commission.

4. Dispute Resolution - Principles and Practices

4.1 Introduction

Good dispute resolution processes are founded in the principles of administrative justice and provide an efficient and flexible approach to conflict resolution. They are structured to allow the disputing parties to collaborate in reaching a consensus and to resolve conflicts mutually before it escalates to a formal arbitration-based process. By following these principles, organizations like the WCB can simplify and streamline conflict resolution processes while providing a service that is responsive to the needs of the stakeholders.

This section will introduce and highlight some of the foundational concepts and basic principles of fairness and best practices in dispute resolution. Our review of the medical and appeals processes in Alberta WCS will seek alignment with these constructs while identifying opportunities for improvement in the systems, processes, and practices from the efficiency and effectiveness perspective.

The Meredith Principles – no-fault insurance, collective liability, independent administration, and exclusive jurisdiction – establish the foundational values for Canada's workers' compensation systems. These principles also guide most of the workers' compensation legislation in Canada. The Meredith Principles gave rise to the need for a non-litigative but effective dispute resolution mechanism that workers and employers can trust.

Additionally, specific rulings have been issued in the past by the Supreme Court of Canada that may be relevant for developing a fuller understanding of fairness and natural justice as it applies to the workers' compensation system across Canada.

WCB's claims process seeks to maintain a balance between workers' access to benefits and the employer's access to affordable protection, with emphasis placed on a safe return to work for the injured worker. While most claims are resolved without issue, disputes do arise. It is in the best interest of all parties to resolve any disputes efficiently and equitably. There are many methods for dispute resolution, some of which are better suited to the context at hand.

4.2 Worker and Employer Rights and Responsibilities

Regardless of the mechanism by which disputes are settled, there are rights and codes of conduct that must be followed by all parties involved. Adherence to these guidelines, at a minimum, assure involved

parties that their right to access, to participate, to understand, and to meaningfully engage in the dispute resolution process is upheld.

Alberta's Code of Rights and Conduct ("the Code"), established under section 9.2 of the WCA in 2018 outlines the rights and responsibilities of workers and employers as it relates to their interactions with the WCB. An effective dispute resolution process must embed these rights and responsibilities within the process. All parties are incentivized to collaborate to reach a mutually acceptable outcome quickly and efficiently.

The Code, available in Appendix 3, includes the following rights and duties:

- Dignity and respect
- Fairness and impartiality
- Full and correct information
- Access to information
- Privacy and confidentiality

4.3 Principles of Administrative Justice

Principles of Administrative justice govern any dispute resolution process, regardless of the formality of the process. These principles, sometimes referred to as "natural justice", "procedural fairness", or "administrative fairness", outline the requirements that must be met prior to an outcome being decided. The principles stem from a common theme of *fairness.* How fairness is defined, quantified, and enacted is contextually dependent but generally includes courteous and respectful treatment, a fair and accessible procedure including clear and timely communication, and an unbiased resolution process.

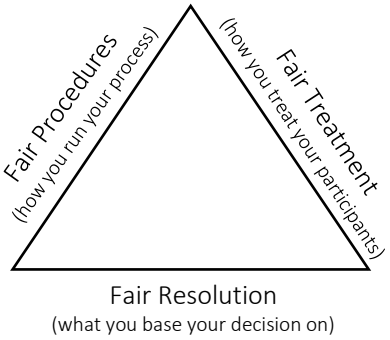


Figure 4.1: A Fairness Triangle for Tribunals (source: Ombudsman Saskatchewan)

To ensure an unbiased decision is reached, the decision maker must be impartial and independent from both the institutions and individuals involved in the process. The decision maker must also preside over the dispute with an open mind, giving due consideration to all the facts and evidence presented by the involved parties.

4.3.1 Fairness Defined

The Ombudsman Saskatchewan developed a framework to conceptualize fairness, as seen above in Figure 4.1. This best practice framework depicts the three main requirements for a fair dispute resolution process: *fair treatment*, *fair procedures*, and *fair resolution*. Building on these requirements, a fair resolution ensures:

1. *Fair Treatment* — All parties are treated with respect, dignity, and courtesy. The process is user friendly and sensitive to the needs of a diverse population i.e., ethnic, cultural, and religious backgrounds, gender identity, physical and intellectual capacity, etc. Information is easy to locate, and participants are provided with support and guidance as required throughout the process. Information is accessible to all users, meaning it is written at an appropriate reading level and available in alternate formats such as audio, or translated to other languages. The physical space in which hearings are held should also be accessible to individuals with disabilities.

2. *Fair Procedure* — The resolution procedure and all relevant information and services should be straightforward to access and easy to understand. Participants must be provided with an opportunity to actively participate in the resolution process. All participants have a right to be heard and to make their views and evidence known. All written and verbal communication is clear, written in plain language, and provided with enough notice and context to allow for meaningful participation in all aspects of the decision-making process.

3. *Fair Resolution* — Decision makers must remain unbiased and impartial throughout the process. They must not have any relationship with the parties or vested interest in the outcome. All decisions must be based on evidence that is founded in fact. The outcome and rationale must be clearly communicated, and parties provided with an opportunity to respond and seek clarification on the resolution. Decisions must be provided within a reasonable amount of time.

4.4 Avoidance

The avoidance of disputes is the ideal outcome for all. Steps should be taken from the outset to prevent and decrease the possibility of disputes arising. Mitigation of root causes, clarity of roles, processes, and policies as well as clear communications and early identification of concerns can help rectify issues before they require any form of resolution.

4.5 Traditional Dispute Resolution

Traditional dispute resolution utilizes litigation to determine which of the involved parties has a greater claim to being in the right. The process is, by nature, adversarial as it is designed to identify one party as "right" and the other as "wrong". Lawyers or other legal representatives are used to present each parties' evidence to their claim while seeking to counter the opposing view. The adjudicatory decision is made by a third party (usually a judge) and the decision is legally binding.

This process can be costly – in both time and financial resources. In addition to payments for legal representation, productivity costs associated with the litigants having to reallocate resources to a lengthy litigation process affect an organizations' bottom line. It is also important to consider the relational costs. The contentious atmosphere that can arise during these disputes can make the return-to-work process difficult, if not impossible. The litigation process itself is formal and complicated with little flexibility and creativity applied to the resolution outcomes. The process typically leaves one party unsatisfied with the outcome. By jumping straight into the litigation process before exploring alternative dispute resolution (ADR) mechanisms, a solution that is acceptable to both parties may be missed.

4.6 Alternative Dispute Resolution

In contrast to the traditional dispute resolution method, ADR is a collection of dispute resolution mechanisms that utilize an incremental, holistic, and simplified approach to dispute resolution. ADR can influence both the process by which resolutions are reached, as well as the range of possible outcomes. As a process, ADR seeks to bring together the involved parties in an informal and collaborative setting to address the dispute as effectively as possible, without resorting to litigation.

ADR approaches abide by the principles of administrative justice. The process is rooted in fairness and places emphasis on an unbiased, clearly communicated resolution. While the ADR process may rely on a spectrum of interventions ranging from informal resolutions to formal arbitration proceedings, the goal of each approach is to conduct a fair hearing that encompasses the requirement on all three sides of the Fairness Triangle.

4.6.1 Attributes of Alternative Dispute Resolution

Accessibility

Throughout the ADR process, emphasis is placed on accessibility. Accessibility takes into consideration the varying levels of understanding of participants and ensures the process is straightforward and user

friendly. Plain and easy to understand language is used for all written materials including eligibility requirements, applications, and resolution explanations. All parties should know where and how to access the dispute resolution process and be able to easily access assistance and clarification when required.

Timeliness

The process should also be timely, providing adequate notice to all parties and returning a resolution within a reasonable amount of time. Adequate notice ensures parties have ample time to gather evidence and clarify any issues relating to the claim. The dispute resolution process should proceed with minimal delays, which can cause further harm and frustration to those involved. Having a clear, well defined administrative process with reasonable statutory timelines can help prevent delays.

Quality of the Decision

The decision maker must ensure their decision is of sound quality. This requires the decision to be evidence-based and consistent with laws and policies. To achieve this, the decision maker must clarify the issue at hand, seek out additional evidence as needed, and consider and apply any relevant laws or policies before making their final decision. The evidence presented must be deemed by the decision maker to be relevant, factual, and given the appropriate amount of consideration.

Decision Making Process

An important distinction between ADR and traditional dispute resolution processes is the ability of the involved parties to participate in and contribute to the ultimate resolution outcome. While the decision maker must remain impartial, their role is to hear all the information and facilitate a mutually beneficial outcome based on the evidence provided. In practice, this means all parties receive adequate notice, information, and a well-reasoned resolution. A well-reasoned resolution is one that clearly explains *why* and *how* the outcome was reached. It reflects on both the legal and practical rationale. The decision maker who was assigned to and has heard the case must be the one making the final decision, ensuring a third-party does not influence the outcome.

4.6.2 Approaches to Alternative Dispute Resolution

Conciliation and/or Mediation

Typically, the formal ADR process begins with an informal conciliation or mediation process, whereby a neutral third party is brought in to facilitate an amicable resolution to the dispute. The third party has no

decision-making power and is present to ensure a respectful and constructive process occurs. Conciliation and/or mediation is based on voluntary, flexible, and interest-based participation from all parties. The goal of this process is to provide an "off-the-record" space for all involved parties to express their concerns and desired outcomes to reach a mutually beneficial outcome. The mediation process fosters collaboration and creative problem-solving, while allowing space for parties to provide input and feedback into the resolution.

Arbitration

If a resolution cannot be achieved during the conciliation or mediation process, it is then escalated to arbitration. Like litigation, arbitration uses a neutral third party to preside over and determine the outcome of the resolution process after reviewing all relevant information. Where arbitration differs is with the flexibility of the decision maker. While still required to follow the rule of the law, the decision maker in the arbitration process has more flexibility to provide a mutually beneficial outcome. Arbitration is used to solve the dispute at hand without having to involve the formal court process and without being limited in the possible outcomes. By utilizing an arbitration process instead of litigation, all involved parties can save financial and human resources. Arbitration is the middle ground between traditional litigation methods and mediation. This process is still rooted in fairness and is utilized by all the provincial worker's compensation systems in Canada for making final rulings on disputes that cannot be resolved with other approaches.

4.6.3 Benefits of ADR

There are many benefits to an incremental ADR process. Firstly, it usually results in a more transparent and equitable resolution process, as it is born out of collaboration and communication between parties. Through sharing of information and the use of a neutral and impartial third party, many of the rights of employees and employers alike are met through the process itself. Additionally, possible outcomes are not limited by case-law or legislation, instead, involved parties can come to a consensus-based decision on each unique case while being bound by the relevant legislation, policy and contractual obligations. Lastly, the costs – financial, relational, and human resources – tend to be decreased when matters are resolved early.

4.7 Summary

- A sense of fairness must govern any dispute resolution process, regardless of the formality of the process.
- Fairness includes courteous and respectful treatment, an unbiased resolution process, and a fair resolution.
- The decision maker must be impartial and independent from both the institutions and individuals involved in the process to ensure an unbiased decision is reached.
- When possible, disputes should be avoided through the early identification of issues and clear communication.
- Traditional dispute resolution utilizes litigation to reach a decision. The process is, by nature, adversarial as it is designed to identify one party as "right" and the other as "wrong".
- ADR processes are a collection of dispute resolution mechanisms that utilize an incremental, holistic, and simplified approach to dispute resolution.
- ADR is based in collaboration and aims to produce a mutually beneficial outcome for the involved parties.
- Approaches to ADR include:
    - Conciliation/meditation – utilizing a neutral third-party to facilitate a mutually-beneficial outcome. The third party does not hold decision making power and instead collaborates with the parties to generate a resolution.
    - Arbitration – a more formal process whereby a neutral a third-party presides over and determines the outcome of the dispute. Arbitration is utilized if the issue cannot be resolved with conciliation or mediation.

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5. Medical Review and Appeal in Alberta - A System Perspective

5.1 Introduction

In this section of the report, we adopt a system's view of the dispute resolution mechanisms in Alberta's WCS. For each component we describe its form and function and conduct a high-level organizational analysis to provide the reader a holistic appreciation of the system.

For each component, we present our observations relative to the current state of the mandate, the function/purpose, operational scale, and the organizational setup. Where applicable we express our observations relative to topics such as institutional independence, decision making model, and service delivery approach. We provide a brief assessment of the opportunities that we identified and recommendations for improvements. Our recommendations draw on principles and best practices for dispute resolution in workers' compensation, including what we identify as practices worth emulating from other Canadian jurisdictions.

5.2 The Alberta Workers' Compensation System at a Glance

The WCS in Alberta consists of the WCB and the AC – together referred to as the System Agencies. A conceptual model of the dispute resolution mechanism in Alberta's workers' compensation is shown on the next page. Some of the foundational documents and basic data related to the system are available in Appendices 2 to 5.

Returning workers to employment is a primary concern for all workers' compensation systems in Canada, and therefore early resolution of disputes related to the adjudication of an injured worker's claim is important. A study in 1987 by WSIB Ontario showed that the probability of an injured worker successfully returning to their workplace decreases exponentially the longer they are off due to injury. Only 50% of workers return to work after 6 months away, 12-15% after one year, and less than 5% after two years. Another study done by McMaster University in 1994 found that if a worker has not returned to work in 3 months, there is a 50% chance that they will not return to work within 15 months. In order to mitigate the risks, one of the most important goals of the workers' compensation system is to enable workers to return to work as early and as safely as possible. Additionally, a safe return to work is important for restoring a sense of independence, job security, income security, and self-esteem in the worker.

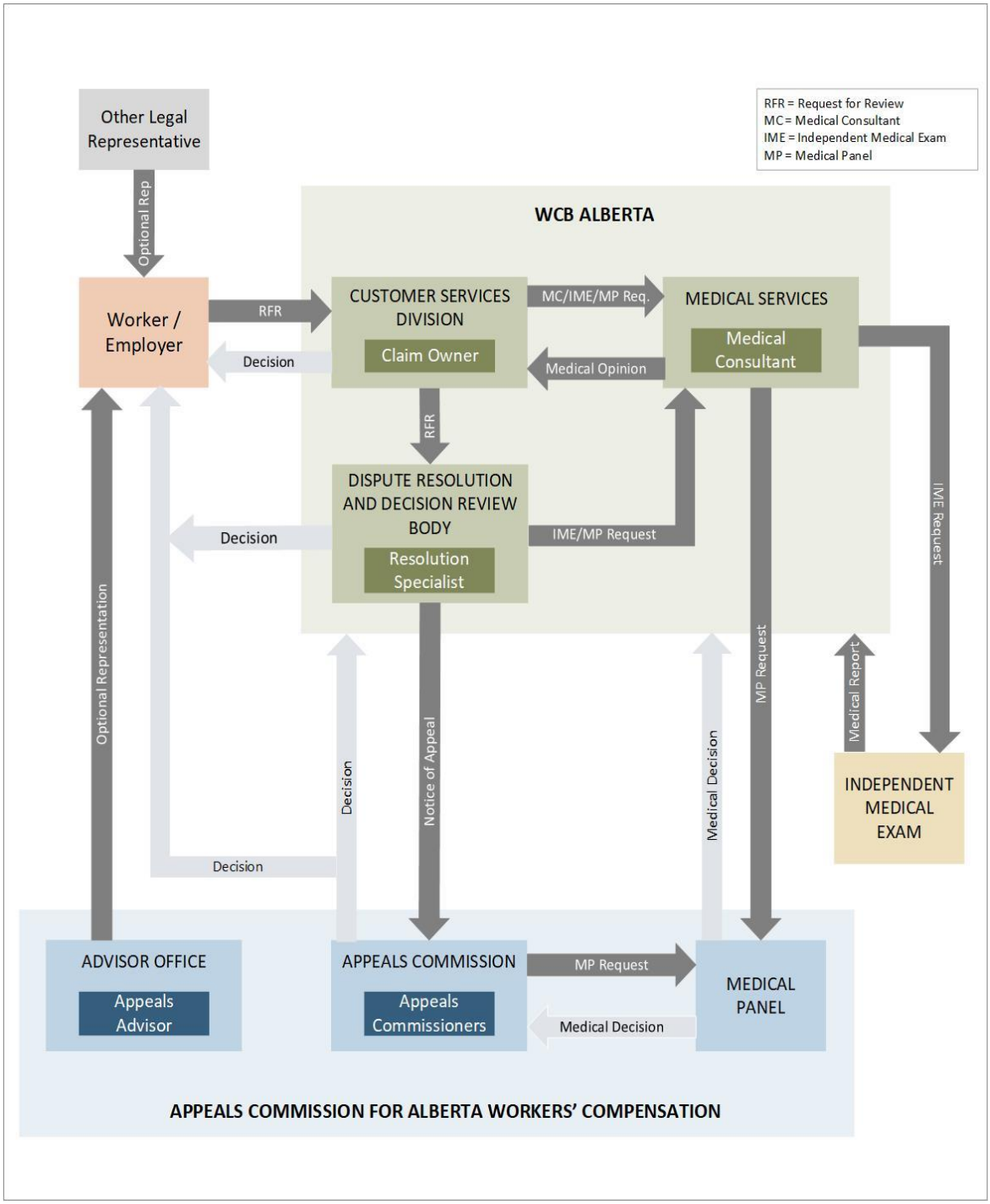


Figure 5.1: Medical Review and Appeals in Alberta Workers' Compensation

The WCB is a neutral and independent administrator of workers' compensation in Alberta. It delivers insurance coverage to Albertans through their employers for work-related injuries, and it provides injured workers with compensation including wage-replacement benefits, medical aid, treatment, training, and supports for their successful rehabilitation and return to work. Not all employers are required to have WCB coverage. Those employers classified in exempt industries may however, voluntarily decide to buy coverage.

The Alberta WCS has the following key agencies and roles that are relevant to dispute resolution and appeals as also reflected in Figure 5.1.

Adjudicators

- Determine initial eligibility for workers' compensation coverage and benefits based on legislation, WCB operational policy, and the facts of the claim.
- Assist with access to medical and rehabilitation resources and provide claim decisions during the initial period of disability (typically initial entitlement and first payment are confirmed and issued within 14 days of receipt of the claim).

Case Managers

- Ongoing management of WCB entitlement and benefits, including investigation of any additional conditions or injuries during the worker's recovery.
- Assess, plan, and facilitate the appropriate benefits and services to promote a safe and timely return to work for injured workers, and to maximize quality-of-life, function, and independence for those severely injured.

Note: The Adjudicators and Case Managers are collectively referred to as *"Claim Owners"*.

Representatives

- Persons who provide advice and legal representation to workers or employers during a dispute with the WCB. They are deemed to be acting on behalf of the worker or employer they represent. They may be system funded Appeals Advisors, fee for service practitioners such as lawyers or advocates, or a free service by an agency or a person.

Medical Consultants

- Provide objective and unbiased opinions based on documentary review of a workers' medical file.
- May communicate with outside physicians to identify treatment options, barriers, and solutions, and to achieve consensus on medical issues impacting claim entitlement decisions.

Independent Medical Examiner

- Provide independent medical opinion based on a physical examination of the injured worker.
- Are practicing medical specialists who are qualified by WCB and work on a contract basis.

Dispute Resolution and Decision Review Body

- A business unit within WCB that conducts statutory reviews of complaints from workers and employers when they disagree with a decision made by a Claim Owner.
- Resolution Specialists who conduct the review can uphold, vary, or reverse the decision made by the Claim Owners.

Appeals Commission for Alberta Workers' Compensation

The Appeals Commission is an independent agency of the Government of Alberta with quasi-judicial powers and appellate jurisdiction on all matters related to the *Workers' Compensation Act* of Alberta. It provides the following services:

- Appeals Commission, to decide on appeals for decisions made by the review body (DRDRB).
- Medical Panels, to decide on medical disagreements related to medical complexity of a claim.
- Advisors Office, to provide on request, advice and representation to workers or employers in their disputes with the WCB.

As can be seen, all the above entities (system agencies and roles) contribute to the value chain that starts with a disagreement with a WCB claim decision and culminates in a resolved dispute at some later stage. When reviewing this report, the reader will notice that we have sought to organize the content to align with this value chain.

The table below provides a selected dataset for each agency to give the reader an appreciation of the relative size of the operations. Additional data is available in Appendices 15 to 20.

2019-20	WCB*		Appeals Commission		
	CSD	*DRDRB*	*Appeals*	*Medical Panel*	*Advisors Office*
Budget	n/a	$1,900,000	$10,794,878	$1,141,859	$3,461,000*
Service Del. FTE	n/a	15.5 Res Spec. 3 RFR Coord. 1 Work Coord.	21 Hearing Chairs 37 P/T Comm. 22 Service support	1 MP Coord. 1 Admin. Contracted Panel members	21 Worker AA 3 Emp AA 3 Case Asstt. 2 Bus Proc Spec.
Referrals	2,738	1,836	507	12	1737

Note: WCB data is for 2019 calendar year, others are for 2019-20 fiscal year. AO budget is for 2020-21 year estimated.

5.3 Disputes in Alberta's Workers' Compensation

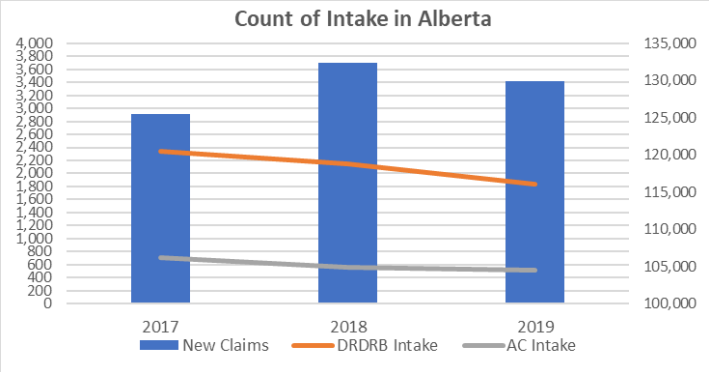
For most workers and employers, the Alberta workers' compensation system has proven to be a fair and effective system. Statistics from WCB show that approximately 2% of all claims that are submitted during a year will have any kind of disagreement or dispute, and about 1.5% of all claims require resolution by the decision-review body. The remainder are resolved through alternate methods. Disputes also arise among cases that have been open from previous years. These statistics for Alberta compare well against other provincial systems. Despite the relatively small percentage, WCB is committed to improving the experience of the injured workers who go through the dispute resolution process.

Disputes can arise when a worker or an employer disagrees with a decision made by the Board. Disputes are generally about decisions related to compensation, medical, or employer assessments. The WCA mandates a two-level formal dispute resolution mechanism if an informal or negotiated approach does not settle the dispute. All dispute resolution efforts begin with the original decision maker. If a resolution cannot be reached with the decision maker, then for the first mandated level, WCA Section 9.3 requires the WCB to establish an internal Review Body to review decisions made by a Claim Owner upon the request of an injured worker or employer. Under Section 9.4 of the Act the Review Body also has the mandate to review decisions related to employer assessments upon employer request. This Review Body is called the WCB Dispute Resolution and Decision Review Body.

The second and final level, the AC, is mandated by WCA Section 10, and has appellate jurisdiction on all matters related to the WCA. Workers and employers can appeal a decision made by the DRDRB in relation to a dispute. The AC is the final decision maker on any dispute under the *Workers' Compensation Act*.

Disputes also arise due to decisions made by the Board on medical information, diagnosis, prognosis and treatment. If a claim has a medical complexity or there is disagreement between the opinions of medical professionals, the Claim Owner can resolve the disagreement by seeking an independent medical opinion from a Medical Consultant or by requesting an IME. If the medical dispute cannot be resolved internally, then the WCA Section 46.3 requires that the dispute be referred to a MP for a final and binding decision.

As the chart indicates the count of disputes at both DRDRB and the AC (charted on the left axis) has declined from 2017 to 2019, although total new claims have increased since 2017.



5.4 Informal Resolution

Disputes are predominantly related to decisions made by a Claim Owner in relation to a claim. Claim Owners work independently to make their adjudication decisions on claims, but do consult with colleagues, supervisors, and policy advisors during adjudication and also for dispute resolution.

Disputes of any nature are first discussed and attempts for resolution occur between the requester (worker or employer) and the original decision maker (i.e., Claim Owner). This is an early stage of informal and collaborative clarification and negotiation. The Claim Owner explains the reasons for the decision (i.e., how the evidence was weighed), and tries to resolve any misunderstanding about the decision, as formally documented in the decision letter. Claim Owners or their supervisors are able to change their adjudication decision for any valid reason at any point in time, or when a person with direct interest has requested a review within the one-year timeframe that workers or employers are allowed to under the WCA.

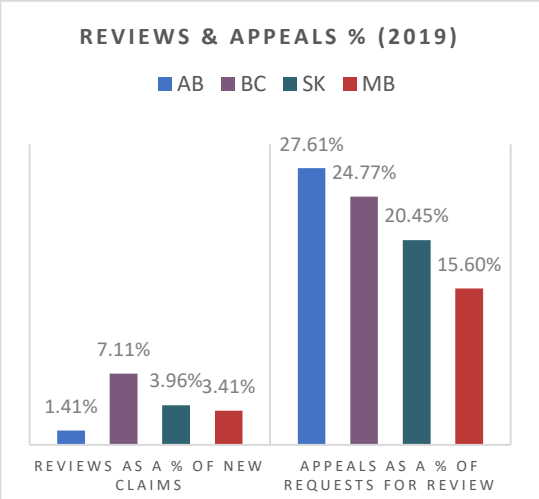
If the worker or employer does not accept the decision, the Claim Owner advises them of their option to request a formal review of the decision. They are also informed of the availability of the appeals advisor service which is a free service to support them during their appeal. Workers and employers also have the option to hire their own professional representatives such as lawyers, paralegals, and advocates.

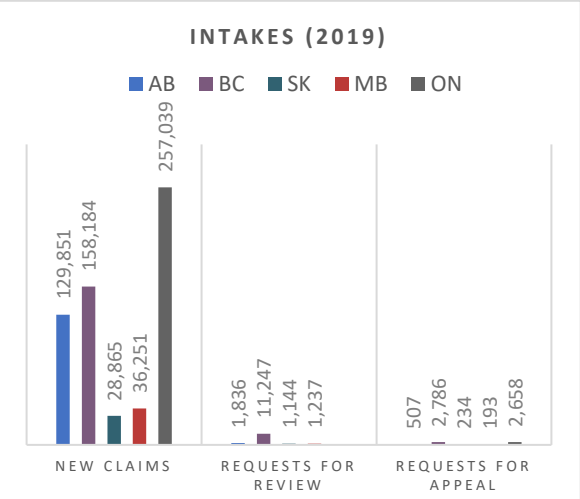
Review & Appeal in Other Jurisdictions

The early resolution process in all jurisdictions we studied are similar to Alberta – the worker or employer must contact the original decision maker first, though in BC this is not mandatory. Only if the disagreement cannot be resolved with the decision maker can they request a review. BC allows a maximum of 75 days for a dispute to be submitted from the date of the decision, whereas Alberta allows 1 year from the date of the decision (as of April 1, 2021). Ontario allows 30 days for return-to-work decisions and 6 months for all other decisions. Saskatchewan and Manitoba do not have time restrictions.

The incremental approach to dispute resolution is common in Canadian jurisdictions. The four provincial systems we studied have an internal review body that reviews decisions made by Claim Owners, and if disagreements remain then an independent tribunal outside the WCB makes a final and binding decision (except in Saskatchewan whose review bodies are both internal). However, the systems are less similar in how they handle medical disagreements and disputes.

The charts below show the difference in the provincial system's operational volumes for new claims, decision review, and appeals tribunal levels.





ON data not available for Review and Appeals.

Note: For all j-scan data sets, when a provincial statistic does not appear on a comparison chart, assume data for the province was not available.

5.5 *The* Dispute Resolution and Decision Review Body

5.5.1 *Mandate*

Section 9.3 of the WCA requires the WCB to establish a three-member "Review Body" including a Chair, who may designate one or more members of the Review Body to conduct a review under section 9.4. Under these provisions, the DRDRB is the decision Review Body that has the power to appoint a reviewer who can overturn, vary, or accept the original decision made by the Claim Owner.

The DRDRB is empowered to review both worker and employer-initiated disputes, and therefore these may involve claims or employer account assessments. The decisions of the DRDRB are binding on all parties, and the only way to challenge its decision is to appeal to the AC.

5.5.2 *Organization and Governance of DRDRB*

The organizational chart below shows the DRDRB as a business unit in the Business Analysis Intelligence and Support area of the WCB Operations and Innovation Division. The Operations and Innovation Division, led by a Senior Vice President, is the largest organizational unit in the WCB. It houses Claims Authorization and Processing, Customer Contact Centre, Employer Accounts and Risk Management, as well as a few other departments.

The DRDRB Resolution Specialists review the decisions that are in dispute. Their Team Lead reports to the Director of the department who is accountable to the Senior Vice President, Operations and Innovation. There are currently 15.5 FTE Resolution Specialists who are supported by four Coordinators and an administrative support person. The three-member Review Body as required by the WCA consists of the Director of the Business Analysis, Intelligence & Support branch as the Chair, the Team Lead of DRDRB, and the Resolution Specialist who is assigned to review the case. The other two members are standing members of the DRDRB but do not have any active role in the review. Therefore, by implication, the three-member DRDRB is not a permanent body but, has a limited tenure for each dispute.

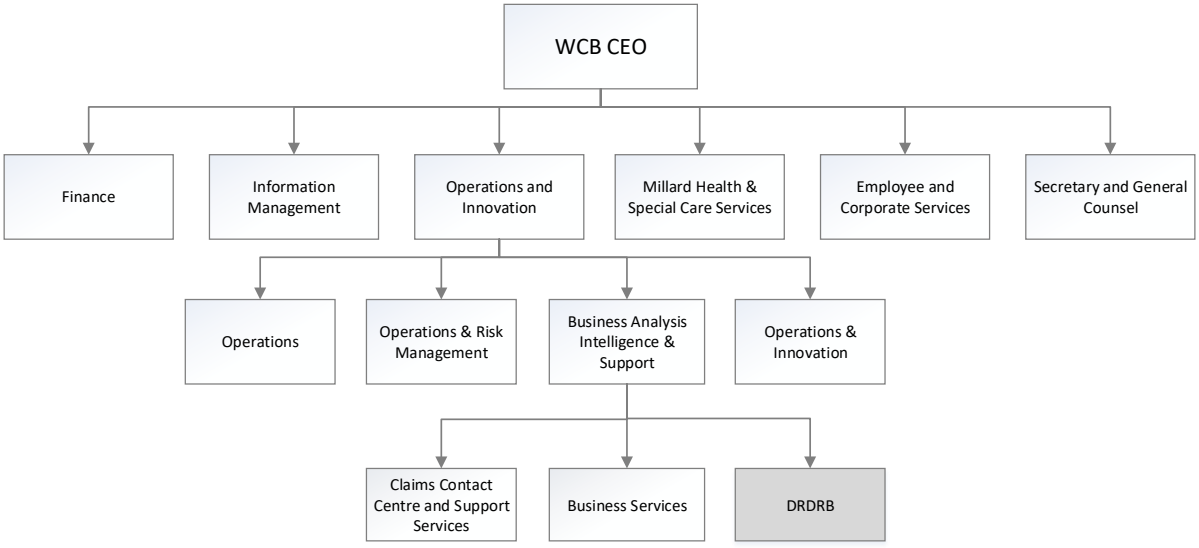


Figure 5.2: WCB Alberta Organizational Structure

According to WCB, the primary focus of the Resolution Specialist role is to:

- facilitate problem-solving and participatory decision-making in relation to disputed decisions;
- provide advice, coaching and mentoring, and sharing of technical knowledge with Customer Service teams in order to facilitate early resolution of disputes; and
- make sound and fair decisions on issues in dispute when resolution has not been achieved through collaborative discussion.

A Resolution Specialist may also be assigned to provide preliminary consultation to the Claim Owner when the request for review is first submitted to the Claim Owner. This is an advisory role to the Claim Owner, supporting the Claim Owner's resolution effort.

Each Resolution Specialist is trained to resolve both worker and employer-initiated disputes. The Resolution Specialists are trained in dispute resolution and mediation and may have prior work experience from within WCB in areas such as adjudication, claims management, employer assessment, policy, or QA. Resolution Specialists who are new in the role receive training and mentoring, and decisions made by them are screened for QA before they are able to independently reviewing cases.

The DRDRB employs Resolution Specialists in permanent as well as in short-term secondment positions within the WCB organization. The temporary staff, about half of the total, are appointed on a rotational

basis. Each rotation can be six months to two years long, and in some cases longer. If not confirmed to a permanent position as a Resolution Specialist these staff return to their original role. WCB considers this as a training opportunity and preparation for future full-time Resolution Specialist prospects.

5.5.3 Decision Making Model

The DRDRB uses a participatory model for resolving disputes in which the Resolution Specialist uses a collaborative approach for sharing information about the worker's dispute, and also for making their decision. At different stages of the resolution process, the Resolution Specialist engages the worker and/or employer and also the original decision maker, usually the Claim Owner and/or their Supervisor.

The DRDRB allows both documents-only reviews and in-person hearings for the resolution process. Some Resolution Specialists use the in-person hearing if requested by the worker/employer only as an opportunity to gain a better understanding of the grievances of the parties involved through their first-hand accounts, prior to reviewing the case file. The other two members of the DRDRB are not present in the hearing, and do not actively participate in the review. They are consulted by the Resolution Specialist as needed.

Until the hearing is held, the Resolution Specialist does not communicate with the Claim Owner, however the process becomes participatory after the hearing, during the decision-making phase. Before finalizing their decision, and especially when their conclusion is different from the original decision, the Resolution Specialist will discuss their conclusion with their own Team Lead, and then meet with the Claim Owner and their Supervisor in an "escalation meeting" to arrive at a consensus. This may be the typical involvement of the DRDRB Team Lead in a decision review. The Chair of the DRDRB is rarely involved. In complex situations, the Claim Owner's Manager may also be involved when the Resolution Specialist's conclusion is to change the Claim Owner's decision. The decision made by the Resolution Specialist is binding on the Claim Owner.

The DRDRB makes two types of rulings: Decision Changed and Decision Unchanged. A case may be sent back to the Claim Owner with a status of "Premature" if the file is not complete in the opinion of the Resolution Specialist.

5.5.4 Analysis and Observations

The WCA is not prescriptive in defining the governance, decision making model, or the tenure of the Review Body. Therefore, from the regulatory perspective, the DRDRB's organizational setup within WCB,

its decision-making model, and its limited tenure specific to each case appear to be consistent with the WCA – in its letter, though not in intent.

However, the review being undertaken according to WCA Section 9.4, is a statutory review of a decision made under the Act. The minimum expectation of a statutory review of a decision made under the Act would be that the decision should be free from any real or perceived bias. By implication one would expect the review be conducted at an arms-length from the original decision maker to avoid any perception of bias. By virtue of its organizational structure and participatory review approach and primarily one person review, the DRDRB's current decision-making model does not meet this expectation. Stakeholders interpret the intent of Section 9.4 to guarantee a fair and transparent process for dispute resolution. Institutional independence is an important pillar that provides an assurance of fairness. Stakeholders (employer and worker) attribute their lack of confidence on the fairness and independence of the review decision to the current organizational structure and decision-making model of the DRDRB.

We also infer from the evidence and our analysis that the DRDRB's participatory decision-making model has transformed into a fairly complex relationship which has mixed attributes of ADR, QA, and capacity building. The approach and format of the DRDRB hearing is neither conciliation nor arbitration-based, which undermines the integrity of the process. Stakeholder opinion indicates that the lack of clarity and transparency has created doubt and distrust amongst them. It should be noted that the DRDRB in its current form with dispute resolution in its mandate has existed since the year 2000. Prior to that, it was purely a decision-making body with powers to reverse an adjudication decision without needing consensus with the original decision maker.

Stakeholder Expectation of DRDRB

During our consultations, the DRDRB decision making process received criticism from most internal and external system stakeholders that we consulted. They cited examples from worker's and employer's experience and the history of DRDRB rulings to support their arguments. The common areas of criticism were the lack of transparency in decision making, lack of independence, poor quality of decisions, and the lack of timeliness. This has led to a significant erosion of trust towards the DRDRB amongst stakeholders. Some representatives even indicated that they only ask for documentary review with the DRDRB because the outcome is almost predictable, and it saves time and effort compared to an in-person hearing. The DRDRB is seen as a necessary steppingstone for reaching the AC. There is a perception among many

internal and external stakeholders who we spoke with that the DRDRB's participatory model undermines the independence and objectivity of the Resolution Specialist.

Worker and employer representatives do not think that the DRDRB's current decision-making model ensures independent and objective decision making. Speaking from their own experience, they see the Resolution Specialist taking a collegial approach in their review. Both groups expressed their perception that the complexity of DRDRB's process for overturning a Claim Owner decision is a barrier in the process.

The staffing model practiced by DRDRB is another aspect that the stakeholders find concerning. Because of the temporary positions, there is always a cross-section of the frontline staff who are on a learning curve and not yet proficient in this challenging role. Given the complexity of skills required for mediation and dispute resolution, having continuity in knowledge and experience would be better achieved with a stable staffing model. The temporary staffing arrangement leaves room for skepticism that the Resolution Specialist's continued attachment or possibility of returning to their old job clouds their objectivity and independence. Based on what we know from organizational behaviour theories, these realities can become influencing factors in the thought process of the Resolution Specialist. Some stakeholders suggest this to be partly responsible for the pattern of decision outcomes from the DRDRB in the past.

Decision Quality

According to the combined data for employer and worker-initiated reviews over the past three years, the DRDRB upholds over 80% of decisions made by the Claim Owner. The percentage is higher when considering only worker-initiated reviews, and is higher than any other jurisdiction as shown in the chart that follows.

Of the cases where the DRDRB did not change the original decision, only 33% proceed to the AC. Based on the total disputes that were initiated, 45% of the cases do not proceed after the DRDRB, even if the decision was not changed. Presumably, this is because there was satisfaction with the DRDRB's decision. However, representatives suggest another plausible reason for workers or employers abandoning their appeal may be due to feelings of exhaustion and frustration, or a lack of financial resources to pursue further.

The outcome from the AC indicates that it confirms 58%, varies 18% of the decisions made by the DRDRB, while the remaining 24% decisions are reversed. The DRDRB's performance from an overall perspective indicates that of the 1,836 cases that came for review, DRDRB decisions are consistent or partially

consistent with the AC decision in about 76% of the cases but are different from AC decisions in about 24% of the cases. This does not consider those disputes that were not pursued beyond the DRDRB for possible reasons stated above.

Timeliness

We reviewed reports comparing actual performance against standards for customer service in the DRDRB. The DRDRB standards require that customer phone queries be answered within one business day, a request for review be acknowledged within five business days, and a dispute be reviewed within 40 business days. Reports that we received from WCB indicate high compliance rates with all these standards. For example, in 2019, 94% of acknowledgements were sent within five days, and 88% of reviews were conducted within the service standard of 40 days.

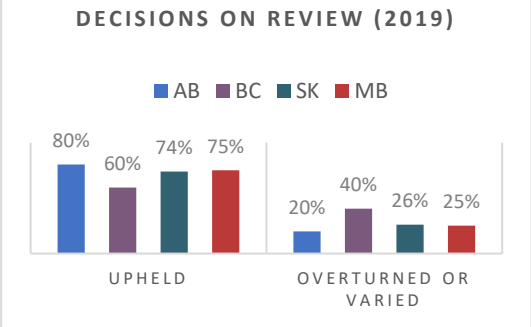
During our stakeholder consultations, we spoke with eight Appeals Advisors and private advocates who represent workers and employers. Most speak of DRDRB acknowledgement letters being late, and reviews taking months, some up to six months to be completed. The difference in the actual experience and the reported performance could be in how the DRDRB calculates the duration. Our analysis revealed that the DRDRB's reported length of time for completing a review does not include days that a review is postponed because only the claimant may request a postponement. Postponement days average over 100 days for more than half the reviews. Therefore, the most likely duration experienced by the average review would be in the vicinity of 100 days. We discuss this issue more substantially in a later section of the report.

Format of Decision Reviews in Other Jurisdictions

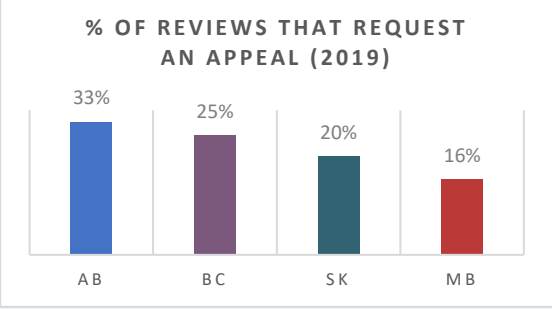
In BC, the Review Division, which is equivalent to the DRDRB, can review compensation, assessment, and prevention related decisions. In MB and SK, the review body can only review compensation related decisions. Unlike in Alberta, the review bodies in all the jurisdictions we analyzed do not have any other service mandate or relationship with the claims and adjudication team such as advisory, consultative, or quality assurance.

In BC, SK, MB, and ON the review body is within the WCB but it operates completely independently and at arms-length from the claims and adjudication function. The review process is independent and does not involve the original decision maker at all, except when the review officer requests additional information. All these jurisdictions apply an arbitration-based decision-making model at the review stage. A higher proportion of reviews in BC are documentary, and the review body also has the power to monitor the implementation of their decision.

When comparing the decision outcomes for the review bodies, we find that Alberta has the highest rate of decisions upheld in favor of the Claim Owner by the review body (DRDRB) at 80%. In comparison, BC upholds 60% of the Board's decisions. The proportion of disputes that get escalated to the Appeals Commission (tribunals in other jurisdictions) at 40% in Alberta is second only to BC which is at 54%.



Additionally, Alberta has the highest proportion of reviews that proceed to request an appeal.



Recommendation 1: Clearly define the nature of the statutory decision review including the authority and accountability of the Review Body referred to in WCA section 9.3/9.4.

Any statutory review must be free from real or perceived bias. The current governance and decision-making structure and processes of the DRDRB are of concern to the stakeholders. The structure of the DRDRB does not reflect established principles of institutional independence as explained earlier in the report. Neither worker nor employer stakeholders are in favour of continuing the current model of the internal review in WCB. The fact that Alberta has the highest proportion of reviews that proceed to the appeal level, when compared with other provinces, may partly be attributed to the lack of confidence in the review process.

The Review Body should be an independent decision-making body within WCB, and arms length from the claims management function in its operation and governance. Like in other jurisdictions, the review body could have an arbitration-based decision-making mandate, with the decision being binding on the WCB. Clarification is also needed with respect to the role of the individual members of the Review Body and their collective accountability.

There is a need to strengthen the trust of the key stakeholders in the DRDRB by implementing a more robust process that demonstrates fairness, transparency and timeliness. An added benefit to the system from this change will be the reduced number of disputes being escalated to the more resource-intensive and time-consuming Appeals Commission process.

5.6 The Appeals Commission

The AC is responsible for three different services in the system. Starting April 2021, in addition to being the appeals tribunal for the WCA, the AC received a mandate to administer the MP and the Appeals Advisor programs. A general description follows.

5.6.1 Mandates

Appeals Commission

The Appeals Commission is a quasi-judicial administrative tribunal that is the final level of appeal on matters related to WCB. The decisions are made by a panel of three Commissioners. It draws its mandate from Section 10 of the WCA and as a government agency it is also subject to the *Alberta Public Agencies Governance Act* and applicable regulations.

The WCA grants a broad jurisdiction to the Commission. Section 13.1(1) of the WCA grants the AC exclusive jurisdiction "to examine, inquire into, hear and determine all matters and questions arising under the Act, on appeals from decisions made by any review body appointed under Section 9.3 of the Act, on appeals from determinations of the Board under section 21(3) of the Act, and any other matters assigned to it under this or any other Act or the regulations under this or any other Act". A restriction on the exclusive jurisdiction of the AC is that it cannot decide on a question of law related to Canadian Charter of Rights and Freedoms. The decision of the AC on the appeal or other matters is final and conclusive and is not open to question or review, except a judicial review.

The WCA grants the AC the same powers as the Court of Queen's Bench for compelling the attendance of witnesses and examining them under oath and for compelling the production and inspection of books, papers, documents, and things. The AC may order depositions of witnesses residing in or outside Alberta to be taken before any person appointed by the AC in a manner similar to that prescribed by the Alberta Rules of Court.

Medical Panel

WCA Section 46(3) allows a MP to be requested by the WCB, the AC, or by the injured worker. The MPs are established when conflicts of medical opinion cannot be resolved by the WCB or the AC.

The MPs resolve differences in medical opinion on a WCB claim, and is a panel of three medical specialists who make final and binding medical decisions. The MP is independent of the AC and the WCB.

Appeals Advisor

The WCA section 13.6 authorizes the AC to establish programs directed at providing independent advice, assistance, and advocacy services. The Appeals Advisor program fulfils this mandate by providing advice, information, and representation to workers and employers who need help with reviews and appeals related to disagreements on decisions made by the WCB. The Appeals Advisors provide their services independent of the WCB and the AC.

5.6.2 Organization and Governance

The organizational structure for the AC and the relationship between its three programs is shown below. The Tribunal, Medical Panel, Advisor Office, and the Secretariat are referred to as "branches".

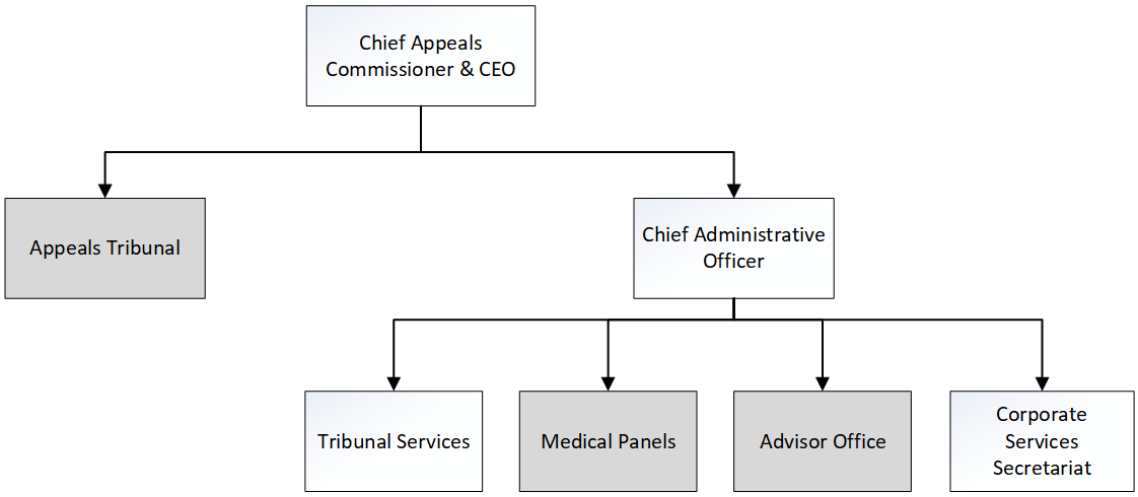


Figure 5.3: Appeals Commission Organizational Structure

Appeals *Commission*

The Chief Appeals Commissioner (CAC) and CEO is appointed through an Order-in Council by the Lt. Governor, and reports to the Minister of Labour and Immigration.

The AC currently has 20 Hearing Chairs (including Vice Chairs) who are also full-time Commissioners, and it has 37 part-time Commissioners distributed between its Edmonton and Calgary offices. The administrative staff who are directly involved in the appeal process include roles like Intake Clerk, Appeals Officer, Hearing Coordinator, and Appeals Assistant who report to the Executive Director of Tribunal Services. The Commission has four hearing rooms in Edmonton and three in Calgary. The cost of carrying out the operations of the Appeals Commission is funded through the WCB Accident Fund.

The Chief Administrative Officer is responsible for the MP, AO, and Secretariat branches, and is accountable for ensuring that effective safeguards to maintain independence between the three services to workers and employers are in place and are effective. The Corporate Services Secretariat is a shared service for finance, IT, facilities, and FOIP/Privacy services.

Medical Panel

The Medical Panels Commissioner (MPC) is appointed through an Order in Council by the Lt. Governor and reports to the Minister of Labour and Immigration. Subject to changes with the restructuring of the Appeals Commission, the MPC will report to the Chief Appeals Commissioner. The CAO is responsible for facilitating the administration and operations of the MP including scheduling, while the Medical Panel Commissioner's role is focused on the review of medical panel questions, selecting the medical panel, and confirming that the Medical Panel has answered the questions.

The cost of carrying out the operations of the Medical Panels is paid from the WCB Accident Fund.

Appeals Advisors

The appeals advisor service is delivered by the AO which has an Executive Director as lead. The Executive Director reports to the CAO.

The AO has two separate, independent teams, one for Worker Appeals Advisor and another for Employer Appeals Advisor. There are 21 Worker Appeals Advisors and three Employer Appeals Advisors located in Edmonton and Calgary offices, in addition to team managers. The cost of carrying out the operations of the Advisors Office is paid from the WCB Accident Fund.

5.6.3 Governance in Appeals Commission

The AC reorganized to include the MP and AO branches on April 1, 2021. A new organizational and governance structure has recently been implemented with an objective of preventing any possibility or perception of risks to confidentiality, institutional independence, and objectivity of the staff who deliver services to the workers and employers (e.g., a single case could involve both worker and employer Advisors, the MP, and the AC). Some of the measures taken by the AC to safeguard against these risks are included in the AC's Governance and Independence framework which is updated monthly:

- continuing with separate brand identities for each of the three core services;
- keeping the tribunal separate from the rest of the branches in its reporting relationship;

- implementing policies that restrict the participation of the Chief Appeals Commissioner in those appeal panels that may create a real or perceived conflict of interest;
- maintaining independent decision-making authority to each of the three services in matters related to client cases;
- implementing policies and rules that bar interaction among client service delivery staff and limit interactions between the branch heads;
- implementing information management and information sharing policies to protect the privacy and confidentiality of client information;
- implementing measures with respect to human resources and performance management to support and safeguard independence and confidentiality;
- implementing measures with respect to communications to support and safeguard independence and confidentiality; and
- separating professional resources such as the general counsel, legal counsel, and secretariat services that each branch accesses.

5.6.4 Observations and Analysis

We reviewed the operational data and performance indicators from each of these services, and compared their performance with equivalent services in the other jurisdictions. We also collected stakeholder feedback through our consultation process. These collectively form the basis of our observations, analysis, and conclusions.

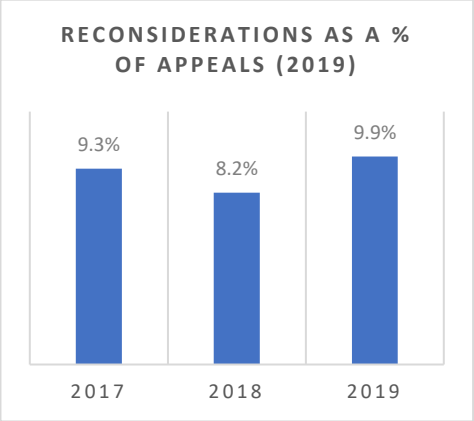
The AC, MP, and Appeals Advisor services are unique and essential for ensuring an effective and robust workers' compensation system in Alberta. Every stakeholder that we spoke with expressed a level of satisfaction and appreciation for the quality of services provided by these system agencies. Stakeholders representing both employers and workers were strongly in favor of maintaining each of these services as part of Alberta's workers' compensation system, however there are opportunities for improvement that were expressed and those that we discovered.

Appeals Commission

The AC provides the appellant the opportunity to have their dispute heard by a neutral third party, which is valued by employers and workers. The AC may give the appellant their first opportunity to sit before a panel and express their concerns. The WCA in section 9.2 Code of Rights and Conduct requires WCB's code to include provisions that provide for the right to participate in decisions that affect them, and to

provide for consequences of, and remedies for, a breach of code. Stakeholders believe that the AC together with the WCB Fairness Review Officer are the guarantors of the Code of Rights for the workers and employers in Alberta.

The AC received requests for reconsideration in 10% of the appeals decided by it in 2019, about half of which were denied. The AC has a process review committee for quality assurance of its key processes, and a stakeholder feedback form available online. At the time of writing this report, we were informed that there are current efforts to create audit tools to audit the quality of the Appeals Document Package and decision standards. The AC is also developing a competency matrix for the Commissioners and a client exit survey to collect feedback on customer satisfaction. In 2019 the AC assessed itself based on industry standards such as Canadian Tribunal Excellence Checklist, Federal Access to Justice Index, and Self-Represented Parties Checklist, and used the self-assessment scores to set targets for improvement.



The Alberta Office of the Ombudsman received three formal complaints about the AC in 2019-20 but did not provide any recommendations to the AC in response to those complaints. AC decisions have been challenged in law courts, but the courts often defer to the AC as a competent authority in dealing with matters related to the WCA. In 2019-20, Alberta courts issued four decisions after a judicial review of decisions made by the AC, all of which upheld the AC's decisions. The general perception of the stakeholders is that the appeals process is fair and objective. A mechanism for QA and client feedback would be highly desirable to ensure continuous improvements in the quality of service and client experience.

Stakeholders are appreciative of the AC's history of maintaining a fair and balanced appeals system and are cautiously optimistic that the three AC branches will continue to operate independently. The duration of the appeal process was mentioned in some stakeholder conversations, though they accept that due process and quality decisions cannot be compromised for shorter timelines.

We heard mild concerns from some representatives regarding the fact that some Commissioners who are past WCB employees do not recuse themselves from a panel or declare conflict of interest when one of the representatives also has been an employee of WCB during an overlapping timeframe. There was no

indication that the decision of the panel was affected in any way. Moreover, the Supreme Court of Canada in Gahir v. Alberta WCB/AC 2009 ruled in favor of the admissibility of former WCB employees as members of an Appeal Commission without apprehension of bias.

Medical Panel

Stakeholders appreciate the role that the MP has within the compensation system by giving finality and closure to intractable medical complexities. The answers provided by the MP enable decisions to be made in the WCB and the AC. All of the stakeholders we spoke with support the need for a mechanism within the workers' compensation system to resolve matters involving conflicting medical opinions, and to render a final and binding decision. Some stakeholders believe that consideration should be given to utilizing the MP earlier in the claim process if medical disputes remain unresolved beyond a time-bound threshold.

The cases that are referred to the MP are extremely complex, as demonstrated by the fact that on average a medical file referred to MP may have over 15 physician consultations and as many different diagnoses, with at least one psych-related diagnosis. As an example, an injured worker sustained a work-related injury in May 2016 and was referred to the MP in early 2021. During this interval, the worker saw 16 general practitioners and 12 specialists in the area of neurology, oral maxillofacial care, physiatry, psychiatry, sleep study assessment, and chiropractor care. Five WCB Medical Consultants had provided opinions on the medical circumstances of the worker. Their past medical history included a previous motor vehicle accident, fibromyalgia, lupus, lupus-related arthritis, irritable bowel syndrome, hypothyroidism, mild asthma, overactive bladder, and Hashimoto's disease. The AC requested the medical panel to answer sixteen questions related to diagnosis, treatment, work restrictions, and functional capacity. This example is typical of the complexities involved in the cases that are referred to the MP.

Comparatively speaking, a very small proportion of the disputes are referred to a MP; 13 were requested in 2019, and 9 in 2020. The medical review needs of these files are singularly complex, and neither the MC nor the IME can resolve them in a manner that is final and binding. The main concern with the MPs among the stakeholders is the length of time it takes a claim file to be referred for a MP, and the length of time it takes to complete the MP process. We analyzed the process time in the MP and provide recommendations in a later section of this report. However, as in the example above and most other cases referred to the MP, the fact that it can be several years before the case reaches the MP deserves further investigation to determine early interventions. In our conversation with the past Commissioner of Medical Panels, there was a suggestion based on the opinion of medical experts that a mandatory independent

review of the medical file could be completed if a medical dispute is not resolved within 18 months of claim submission.

A very small number of workers and representatives have had experience with MPs. We reviewed the exit survey feedback and evaluations done by panel physicians and injured workers or their representatives. Based on the scores achieved, the reports indicate a high degree of satisfaction with the level of expertise in the panel, fairness, and transparency in the medical panel process. During our stakeholder consultations, we heard support from employer and labor organizations, Claim Owners, Resolution Specialists, and AC for continuing the service because of its unique value.

Recommendation 2: Require an independent review of the medical file when a medical dispute remains unresolved and determine an appropriate timing of this review.

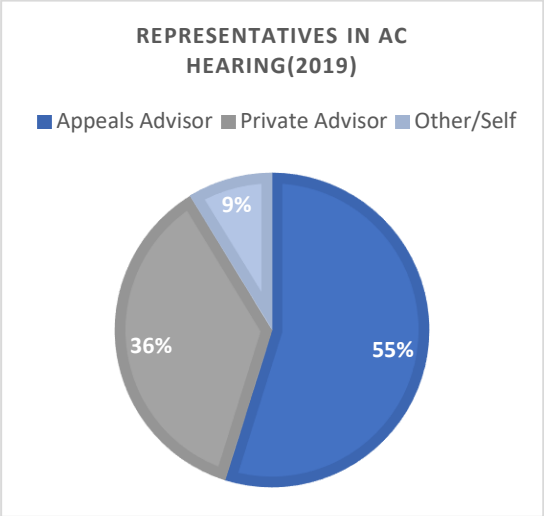
Extraordinary situations among injured workers deserve a differentiated response and interventions in their case management. Most of the referrals to the MP have an accelerating pattern of deterioration in the worker's condition. A case could be made that proactive decisions and early intervention could prevent some of the ailments experienced in the later stages of their medical history.

A full review of the medical file by independent medical experts, based on an assessment of the complexity of the medical file, would allow the WCB to be proactive in the medical care of the injured worker and potentially avoid further complications. This may potentially reduce costs, not just for the compensation system but also for other provincial supports, by reducing related investigations and treatments, while minimizing psychological consequences to the injured worker and their families.

Other intervention approaches such as BC's requirement of a mandatory conversation between the WCB medical advisor (MC equivalent) and the Treating Physician to discuss a return-to-work plan when the worker has been off-work for more than 8 weeks should also be investigated. Ontario has a four-week threshold for involving a return-to-work specialist and an inter-disciplinary health assessment for complex cases at any stage.

Appeals Advisors

In 2019 for AC hearings, 55% of injured workers and employers chose to be represented by an Appeals Advisor, while 36% were represented by other paid professionals, and 9% were self-represented.



The appeals advisors had a merit review process at the intake phase followed by a detailed file review. The merit review process was successful in early resolution and in reducing the necessity of disputes going into formal dispute resolution by up to 40%. The merit review has been discontinued since the restructuring of the appeals advisors with the AC in April 2021. A pre-assignment review is now being done to identify appeal issues, filing deadlines, scope and jurisdiction. The outcomes achieved by the Appeals Advisors in the formal processes with the DRDRB and AC are positive. Injured workers and employers represented by Appeals Advisors' have a higher chance of a successful appeal with 45% of appeals represented by them being reversed or varied, compared to the private advocates and self-represented workers who achieve 35% reversed or varied.

The Appeals Advisors have their own service standards, but for the most part they follow the timelines and procedures as required by the CSD, DRDRB, and AC processes. In the last few years due to high vacancy rates in the advisor roles, they have experienced challenges in meeting their timelines, but we did not hear any major concerns in this regard from any stakeholder. Some Appeals Advisors indicated that the 2-4 weeks for the file review, and the fact that some workers did not qualify on the merit review which was in place prior to April 2021, may be prompting them to seek private advocates. This may also partly explain the lower success rate of the private advocates in terms of decisions reversed at DRDRB and AC.

The stakeholders who we interviewed support the availability and continuation of a system-funded advisory service, both for employers and workers. We reviewed the feedback from the client satisfaction surveys conducted by the Fair Practices Office in 2019. The survey report does not separate the response data for the Appeals Advisor service but the overall satisfaction with the quality of service collectively is above 80%. We found some of the comments provided by the workers and employers referencing the Appeals Advisor staff to be very positive, indicating a high level of appreciation.

The WCB Supervisors and Resolution Specialist who we interviewed also endorsed the role of the Appeals Advisors. In their opinion, the Appeals Advisors are very knowledgeable of the WCB policies and practices and they bring both a neutral perspective, and a humanistic approach to a relationship in which there is a dispute. They suggest exploring avenues for involving the Appeals Advisors earlier in the process under specific situations, such as when an adverse adjudication decision is imminent in a psychological injury related claim, or when an injured worker is vulnerable to misguidance by another person.

The reorganization of the Appeals Advisor service to the AC starting April 2021 raises uncertainty among some affected stakeholders about the future of the nature of the service. Institutional independence is an important requirement under the principles of fairness. The Appeals Advisors are not decision makers however their organizational association with the final decision maker may become a victim of misperceptions, especially if future performance deviates from the past. Both the AC and the Appeals Advisors enjoy a good reputation and a healthy relationship with their clients. In a worst-case scenario there could be some risk to their established reputation if perceptions are not managed proactively.

Service utilization and decision outcome are the key indicators of program success. In 2019, 55% of appeals were represented by Appeals Advisors and they were successful in reversing or varying 45% of the DRDRB decisions. They also resolved more than half their intake before starting a formal process with the DRDRB. The appeals advisor services are not necessarily contributive to the service utilization of the AC. This has some potential for conflict. One can be sure that stakeholders and critics will be watching closely how business decisions regarding the AO are made in the future, and if it is being supported from senior leadership in the AC. Most stakeholders expressed confidence that the AC was capable of managing any real or perceived conflict.

It is also important to recognize that the reorganization of the Appeals Advisors to the AC makes the system susceptible to exploitation by those who compete with the appeals advisor service. The Appeals Advisors have a positive reputation overall among the stakeholders which, if affected even from rumors fueled by misperceptions, will likely result in lower utilization. This scenario will be counterproductive to our other recommendations which support increasing access to the service. Alberta is the only province among the five major systems that we studied, where the Appeals Advisor service is not situated outside the workers' compensation system.

Recommendation 3: AC to continue risk assessment and strategies to mitigate any potential challenges emerging from the reorganization of the Appeals Advisors with the Appeals Commission.

The Appeals Advisor service is valued by the workers as well as the employers. It is an integral part of the system and aligns with the principle of supporting the worker in their time of need. Its continued viability and success are critical for the system. The restructuring has created a new model not used in any other jurisdiction we studied. There is an air of hopeful caution among a section of stakeholders.

The risk may only be of perception, but we know from history of workers' compensation itself that perceptions can take a life of their own. Only time can tell whether the real or perceived risk can be managed or not. We understand that the AC is taking some planned steps to address any potential risks. Whether or not the ministry should take a chance by maintaining a status quo is debatable. Looking at the potential consequence of maintaining the status quo, the worst-case scenario is not acceptable.

The next 1-2 years may be crucial for understanding the dynamics better, however any negative impact might take longer to become conspicuous. A pre-emptive approach is advisable.

5.6.5 Opportunities for System Improvement

Information Sharing

The WCB, AC, AO, and MP are separate and independent from each other. In order to enable each agency to perform their responsibility under the Act, they are entitled to receive information related to the issues that are appealed. The WCB is required to make any such information, including personal information relevant to the dispute or reviews, available to the agency that needs it in order to perform their statutory responsibilities. Subject to WCA section 13.2(5.2) the WCB has created information sharing agreements with the AC to ensure these exchanges are in compliance with relevant laws and regulations regarding confidentiality and information security. The WCA also authorizes the WCB and the AC to release all relevant medical and personal information to the MP when a request for a MP is made.

The WCA section 147(4)(b) states that for the purposes of a decision review or an appeal, the worker, the employer, and their representatives/agents are entitled, upon request, to receive, and the WCB is authorized to disclose, information including personal information that is related to the claim or matter under review or appeal. The worker and employer Appeals Advisors are the legal representatives and agents respectively, referenced in this section of the Act. The AO that provides advice and representation to workers and employers during their appeal, is a legislated service provided by the Appeals Commission under section 13.6 of the Act.

During our consultations with the Employer Appeals Advisors, which is a relatively new service since 2018, we were informed of concerns related to the restrictions and delays on their access to worker's claim information during dispute resolution at the WCB level. The Employer Appeals Advisors are representing employers in an appeal initiated by the worker, or when an employer has requested an appeal against a decision made by the WCB. In either case, the Employer Appeals Advisor requests the claim file in order to prepare for the hearing so they may appropriately represent their case. They have raised the concern that firstly, they do not get access to the file at the same time as the Worker Appeal Advisor. And secondly, in certain cases, they do not get access to the same information as the Worker's Appeal Advisor. We heard from Employer Appeals Advisors that the information they receive from the WCB regarding workers with psychological injuries is highly redacted. Though Worker and Employer Advisors are subject to the same laws and regulations respecting confidentiality and information security, this practice does not reflect an even-handed approach by WCB and presents barriers for the Employer Advisors. WCB's reasons for exercising their right to redact information is based on concerns for information security, and their perception of relevance of the information to the specific request.

Legal opinion obtained by the Employer Appeals Branch on this matter supports WCB's right to determine what information can be disclosed to another body in the worker's compensation system. The FOIP Act prevails over the WCA and therefore, the WCB applies a "relevance test" to determine which parts of the worker's record can be shared with the employer. WCB reviews the request for worker's information case by case and determines which parts of the record can be shared with the Employer Appeal Advisor. Information that they deem not relevant to the issues on appeal are redacted. These typically include past medical information, diagnosis, test results, etc. When redacting, the WCB should follow FOIP requirements and identify what information is being redacted, why, and under what provisions of FOIP.

Employer Appeals Advisors state that there is subjectivity in the redaction by WCB. It places the Employer Appeals Advisors at a disadvantage in claims with psychological injuries, as the WCB redacts most of the background information, pre-existing conditions, and the detailed assessment. This does not allow the Employer Advisor to represent their client adequately in the early resolution attempts with CSD and DRDRB. These reviews have little chance of being resolved before reaching the AC. When the same case reaches the AC, the Appeals Document Package is provided to both the Employer and the Worker Advisors, and it has all the relevant information.

After reviewing communications between the WCB and the Employers Advisor Branch (EAB), as well as the legal opinions obtained by EAB, we understand that WCB's risk perception does not emanate from any real or perceived risk of the Employer Appeals Advisors having the information, who are an authorized agent under the Act acting on the employer's behalf. WCB's practice of redacting information is driven by the need to mitigate any risk of the information being released to the employer. Legal opinion also suggests that, if requested by the Worker Appeals Advisor, the WCB may choose to release all the information or redact any information, including personal information due to provisions in the Act.

There are also administrative hurdles in the process that only the Employer Appeals Advisors encounter. Employer Appeals Advisors do not have access to the worker's claim record, so they need to request the specific information from WCB. WCB requires the Employer Appeals Advisor to provide the date of the disputed decision and it takes 15 days to receive the information. If for some reason the decision date was incorrect, WCB only informs the Employer Advisor at the end of the 15-day period, and a new request has to be initiated. In addition, the Employer Advisor only receives information which is current up to the date on which WCB approves the release of information. Any information, including evidence that is added to the worker's record after that date, is not available to the Employer Appeal Advisor.

In April 2021, the AC signed a memorandum of understanding with the WCB that facilitates and sets the parameters for sharing of claim information through direct access to WCB's Electronic Claim Organization (eCO) system for the Worker Advisor Branch (WAB). The agreement does not allow WAB to share information with the EAB for any legitimate purposes under the Act or otherwise, and the EAB is prohibited from having access to the eCO system.

Recommendation 4: WCB facilitate sharing of relevant worker data, under appropriate assurances, which the Employer Appeal Advisors are entitled to for conducting their statutory responsibilities.

While WCB's concerns with data security may be legitimate, the practice of redacting client data without understanding the needs of the Employer Advisor in the specific dispute appears to be subjective. The WCB could develop appropriate policies for determining on a case-by-case basis what information, if any, may be redactable. A conversation to understand the specific needs of the Employer Advisor in the context of the specific case might be helpful in this determination. WCB could reconsider its decision of not sharing certain data in light of the legal opinions expressed and by the fact that if and when the dispute is appealed to the AC the Employer Advisor would get the same information that the WCB is redacting.

The need to share the necessary information is not just required to maintain fair representation, it also supports timely resolution. Quite likely the disputes in which the Employer Advisor did not have the necessary information from the claim file will escalate to the Appeals Commission, when in fact it could have been resolved earlier had the same information been available to them.

In order to facilitate the sharing the WCB could ask the EAB to provide necessary assurance that the Employer Advisor would not disclose to an employer any information obtained from the WCB that the WCB itself would not disclose to the employer.

In Ontario and Manitoba, the Board requires the worker to approve any release of specific health information to the employer's agent, condition to appropriate safeguards. A similar approach could be taken in Alberta.

Data and Reporting

Our review collected a variety of medical and appeals related data provided by the system agencies. We encountered a few challenges related to the operational data and reports that we received and hope that identifying them here will facilitate addressing them through data and information management strategies in the medical and appeals systems in the future.

a) WCB's eCO system is the single source of all claim related data, though there are other subsystems which extract data from the eCO system for analysis and reporting. The AC uses the Appeals Commission Electronic System (ACES) for case management, and the MP uses a customer relation management system built on iSight. We discovered that data for operational indicators, such as case count reported by the system agencies, is not consistent from one report to another, and from one agency to another. Volume of activity sent to us often did not match counts reported in public documents like the Annual Report and other publications. We received appeals data from WCB, AC, and AO, and discovered that the numbers often do not match even after accounting for the difference in reporting standards. There is inconsistency in the count of cases that WCB reports for various dispute resolution stages from one report to another, and with what the agencies state in their own reports. This may indicate a lack of common definition for some basic data items related to disputes, causing inconsistency in interpretation. In addition, the difference in reporting timeframes, due to different fiscal years (WCB reports on a calendar year, whereas all others report on April 1-March 31 fiscal year) of the agencies creates an inherent challenge in comparing case counts.

b) There is a lack of consistency in language and terminology used among the agencies, for example how decision outcomes are reported by the system agencies. When the WCB (CSD and DRDRB) or the AC make a decision on a disputed issue, the outcome is to be coded under a specific type as defined by policy or legislation. WCB Procedure 3.1B provides a list and explanation for Review and Appeal Terms. WCA section 9.4(5) also specifies the types of decisions the Review Body can make. We observed that there are differences in how the decision outcomes are referenced in various documents such as legislation, WCB procedures, operational reports from WCB, and in reports from the AC. The inconsistency is especially conspicuous in how one agency refers to the decision outcome of another agency. The fact that each one uses its own nomenclature for the outcomes is confusing. Using a consistent nomenclature for the decision outcomes would be more convenient, easier to follow, and more reflective of a single system.

c) We found that the reporting of data, and possibly data capturing is not aligned with the needs of performance management and continuous improvement. We discovered that operational data for some key indicators that would be helpful in targeting improvements, were not being captured. For example, the system does not report on the reasons for postponement, although postponements add an average of 105 days to DRDRB timelines and affect 55% of cases. There were also information gaps in the tracking of medical processes, for example the operational or medical reasons for requesting an IME is not tracked, only the physician's specialty is available. There were other similar examples of data items which, if available, would improve managements' ability to monitor and manage the processes more effectively.

d) The DRDRB and the AC report the duration it takes from intake to the hearing date of a dispute, but the timeframe does not include the effect of postponements or adjournments. In the case of the DRDRB, up to 55% of cases get postponed by an average of 105 days due to both internal and external factors. However, the DRDRB reports an average completion of 40 days for 80% of its disputes. Similarly, the AC reports an average of 170 days from intake to hearing, based on the first hearing date offered to the client. Often the client requests a different date, or the date is postponed later in the process, or the hearing is adjourned after convening. The days lost due to these reasons are not included in the count. If these days were taken into account, the average duration is 272 days for initial appeals. In other words, both the DRDRB and the AC report a notional duration which most likely the average client will not experience. When this data is in a public document or an accountability report, it is not accompanied with an explanation.

e) Both the DRDRB and the AC count their intake volume in number of cases, each case being a worker or an employer's request or appeal respectively. Each case/client's dispute may have one or more issue. Issues from the same case may take different pathways in the resolution process of the DRDRB or the AC. Both the agencies track their work and outcome in the count of issues and by case, but their external reports only show performance in count of issues. While this makes sense for operational management and for an internal audience in the agency, it is inconvenient for an external audience to relate the reported output to the input number of cases. It would be more meaningful if external reports state the input and output in terms of number of cases, in addition to issues.

Recommendation 5:

a) Create an information strategy that supports alignment in data definition and data capture for better performance management of medical and appeals processes across system agencies.

b) Create reporting standards with common indicators and measurements for reporting the operational performance of decision review and appeals seamlessly among system agencies.

The Alberta Workers' Compensation system is lacking a systemic approach to information management relative to medical review and appeals. Good information management starts with better data. Some parts of operational data that are important for quality of service, and process performance management are not being captured.

Data driven performance management relies on factual data to make informed judgements and decisions about processes and systems, which demands seamless data from one system agency to another. WCB could lead the way in defining a data strategy which would support the needs of all the system stakeholders, enable better performance management, and bring consistency and uniformity in reporting.

An added consequence of a data driven performance management approach is that it will drive enhancements to the data capture systems (case management systems) in all the system agencies. This would be highly desirable since the lack of performance related data may possibly be due to limitations of the case management systems currently in use in the WCB and the AC.

5.6.6 Performance Management, Quality Assurance, and Continuous Improvement

The quality of decision-making processes and dispute resolution processes were central to our evaluation of the medical and appeals systems. We collected information on quality control and assurance practices in the key areas that affect decision making and resolution. We have the following observations:

Quality Assurance in Customer Services Division

CSD has a quality assurance team which audits the decision letters written by adjudicators and claim owners. The audit is based on a sampling of the letters and attachments that are sent to workers and employers. The resource capacity of the quality assurance team does not allow for adequate sampling size that would account for all the different types of letters that are written by CSD. Priority is given to decisions identified as high priority, and the remainder are randomly selected in equal proportion of denial letters and fitness for work letters. The same audit tool is used for evaluating the different types of

decision letters. The audit tool, which has five evaluation criteria, is focused on assessing the quality of the decision, not the process, or the communication value of the decision letters. The tool checks for factors related to the decision such as, is the decision appropriate, are benefits tied to the decision, and does it address the concerns. The tool does not assign any weights to the factors, and evaluation is based on a binary rating of yes or no for each affirmation statement. The audits are conducted after the letters have been sent, therefore it does not serve as a quality control mechanism. Some supervisors in the psychological injury unit will review the decision letters before they are sent out. The audit data is analysed and reported at a departmental/business unit level. It is not used for providing individual feedback to staff or for training purposes.

CSD also has a "passport" system for newly appointed adjudicators and Case Managers. The "passport system" includes training, mentoring, and coaching for a period of time until the staff is able to work independently based on their demonstrated quality of work.

Quality Assurance in DRDRB

The DRDRB used to conduct quality assurance of its decision letters, but the practice has been discontinued recently. The tool that was used consisted of eight different factors reflecting the quality of the decision, the process, and the communication value of the letter. Each factor had one or two criteria which are scored on a binary basis as met or not met. The DRDRB achieved an overall score above 97% in the last two years. A binary scoring system does not allow for a scale-based differentiation in quality and therefore limits its ability to identify improvement opportunities. The consistently high overall score indicates that either the tool has outlived its utility, or the evaluation is based on a low expectation of quality.

Similar to CSD, the DRDRB has a "passport" system for newly appointed Resolution Specialists. The approach includes training, mentoring and coaching for a period of time until they are able to work independently based on their demonstrated quality of work.

The DRDRB reports performance on completion time, decision outcomes, and service standards. However, based on our findings during the review, reports and data that are at a level of detail that enables insight-based analysis of known concerns like timeliness and quality of decisions were not available. DRDRB also does not conduct any analysis of trends and patterns based on the reviews that are requested. We were informed by WCB that it conducts ongoing customer satisfaction surveys, but questions related to DRDRB

are not asked in the survey. The collection and analysis of the DRDRB data would have provided WCB with the insight needed to reduce errors and inconsistencies in adjudication that cause disputes.

Quality Assurance in Medical Consultants

The Medical Services branch conducts quality assurance of the memos written by the Medical Consultants based on a peer-group audit approach. The objective of the quality assurance is to ensure that documents prepared are useful to case managers and other Medical Consultants who may be assigned to the file. The Medical Consultant's score in the quality assurance audit accounts for 33% of the weight among five factors included in the calculation of their performance and diligence incentive pay. There are six regular Medical Consultant auditors and they follow a schedule and sampling approach to execute their audit plan. The audit scores are reported both at individual Medical Consultant level and for the team, and used for coaching and improvement, as well as incentive payments. Over the last few years, the average score has been above 98%. A consistently high scores like this usually indicates either the output has reached the highest level of quality, or there is deficiency in the measurement scale, which does not allow enough differentiation based on quality.

WCB also conducts an internal stakeholder survey to collect feedback from the Claim Owners about their relationship with the Medical Consultants under three categories including helpfulness, approachability, and availability. The most recent survey in 2019 indicated an overall satisfaction rate of 89% for the Medical Consultant among Claim Owners.

Quality Assurance at the Appeals Commission

At the time of writing this report, the AC had limited quality assurance of its processes, communications, and decisions. A process review committee for quality assurance of its key processes exists, and a stakeholder feedback form is available online. We were informed that the following quality assurance measures were being planned:

- Decision Standard Audit
- Appeals Document Package Quality Assurance
- Commissioner Performance Management Framework
- Client Exit Survey

The AC has conducted some organizational self-assessment against Canadian standards such as Federal Access to Justice Index, Canadian Tribunal Excellence Checklist, and the Self-Represented Parties Checklist and plans to utilize these tools for future improvements.

The performance indicators shared by the AC were the same as those in its annual report, primarily related to service standards, timeframes, and decision outcomes. The AC does not conduct any value-added analysis of its data to identify correlations or trends in disputes or types of errors that would inform process or policy improvement at other levels of the system. It does analyse data related to request for reconsideration of its own decisions to identify and correct the reasons for those errors.

Quality Assurance in Advisors Office

In January 2020, the AO when it was in the FPO, created a quality assurance framework which included a tool for file audit, client satisfaction survey, and other tools to control and measure the quality of inputs, processes, and outputs. The AO implemented the file audit tool in 2020, but the data is not being leveraged for intelligence gathering and continuous improvement. The AO does not conduct client satisfaction surveys but receives client feedback through informal channels.

Performance is measured in terms of volume of work and outcomes achieved at various levels of dispute resolution. The Appeals Advisors timelines are mostly driven by the scheduling of events by DRDRB and AC. We were unable to confirm how well the AO meets its own service standards, since the AO does not create any reports and such reporting has not been used for managing service standards historically. A report on their performance in the quality assurance audits also does not exist. Their client satisfaction surveys which was done for the whole FPO in 2019, indicates high level of satisfaction for communication and timeliness.

Workers' Compensation System Assurance

The above description of the performance management and QA practices across the system agencies indicates that the system is not well aligned. Each agency exercises performance management and reporting in a limited scope. As indicated earlier, there are inconsistencies among system agencies, and any systemic approach to performance management is absent.

The QA and performance management in the system occur in organizational silos, and not with a system approach. This indicates a failure to recognize that the processes from the CSD to the AC are part of the same value chain, the same client files flow through each of the different parts of the system, and the

quality of one process has implications for the downstream process. As a consequence of a disjointed performance management approach, there is no intelligence or insights transferred from one part of the system to another, and the system as a whole is missing out on opportunities for improvement. An example is the lack of analysis or reporting on trends based on appeals data, which could be leveraged to gain insights on the entire value chain from the quality of adjudication in CSD to the quality of decisions in the AC. This data could potentially provide valuable intelligence such as identifying procedural and policy gaps, and the types of issues at dispute which can be very helpful in policy review, process improvement, and training design.

Either agency could conduct a system-wide analysis of disputes on a periodic basis. It will enable lessons learned to be incorporated and changes to be implemented from a system perspective.

Recommendation 6:

a) Strengthen the quality control and quality assurance practices for all key determinants of process outcome such as: MC memo, adjudication decision letter, DRDRB hearing and decision making, AC information package and hearing, MP hearing, and AA initial review and representation.

b) The Workers' Compensation System should report annually on analysis of trends for disputed decisions and the quality assurance of decision-making processes from adjudication to appeals.

Fundamentally, appeals occur due to deficiencies in the quality of the processes that precede it, including the process of clarifying the adjudication decision to the claimant. Addressing those quality issues are a definite way of reducing the number of disputes.

The quality assurance practices in most parts of the system are inadequate. For example, neither the DRDRB nor the AC do an exit questionnaire after the hearing, nor do they conduct a client satisfaction survey of their client population. Where there are some quality assurance practices in place, it does not include the right measurements, or the reporting does not leverage the data. In addition, by not closing the loop with feedback and lessons learned, it is lacking in value adding continuous improvement. As demonstrated by the narrow definitions of the quality assurance processes and the lack of quality-of-service data, Alberta workers' compensation system has not adopted the philosophy of performance management in the system context. Improvements happen only when there is measurement and when the data is utilized.

Dispute and appeals data can provide valuable insights into the weak spots in the systems processes, policies, procedures and human resources from the beginning of adjudication to the end of appeals. WCB could put the necessary data systems and analytics capability in place to leverage this data for continuous improvement. Reporting on this data should become a new defined accountability within the system.

In addition to using quantitative assessment and reporting as a quality assurance tool, the system agencies could also conduct fairness assessment of their processes and decisions. The Ombudsman Office has a comprehensive "Fairness by Design" assessment tool that the DRDRB and the AC could utilize to assess their administrative fairness and identify the areas of organizational improvement.

Quality Assurance in Other Jurisdictions

British Columbia

QA within the Review Division is led by a Director and senior managers. In addition to providing Review Officer training and advising on specific cases, they investigate and report on QA issues and trends seen by the Review Division. They perform independent audits of files to investigate quality measures, and also analyse trends or patterns of recurrent issues. The results of the audit are utilized in designing their training and in policy review processes.

The Appeals level (WCAT) has a Tribunal Counsel Office that is responsible for QA. In addition to internal audits, they communicate with other levels of the system to improve processes and policies.

The QA teams in Claims Management, the Review Division, and WCAT discuss high level quality issues. In addition, QA completes monthly reviews on WCAT decisions where a Review Division decision was changed. If the reason for varying the decision is based on an error in law or policy, it may also be forwarded to the policy department for analysis.

Saskatchewan

Only Claims adjudication department completes QA, but it does not pertain to reviews and appeals.

Manitoba

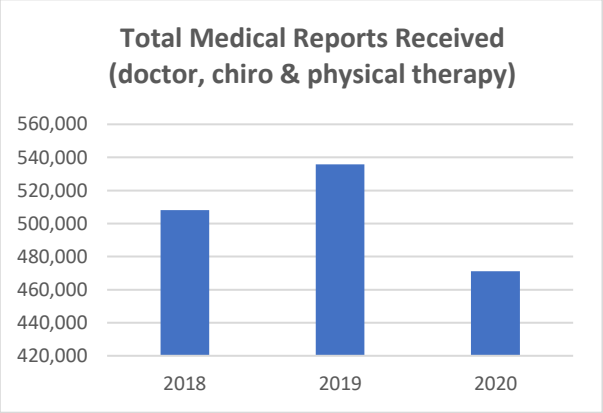
QA in claims adjudication is managed by an Operational Manager within the department.

The Director of the Review Office completes all QA assessments. They review all cases overturned by the AC, primarily looking at what led to the change in ruling and whether it concerned a misapplication of policy or the Act. The Director also monitors for trends. If they find a certain type of decision is repeatedly being overturned by the AC, the manner in which itis adjudicated will be reviewed. These trends, along with statistics, are also shared with the Operational Manager responsible for QA within claims adjudication.

5.7 WCB and Alberta Health

Workplace injuries are subject to the WCA and therefore, all related costs of treatment and reporting are paid by the WCB in each province – funded by employer premiums. These medical and rehabilitative services are not subject to the *Canada Health Act*. However, provincial health services, such as Alberta Health (AH) do have a crucial role in all the workers' compensation systems. The injured workers continue to receive their ongoing treatment for the work-related injury from their family physician or another community physician (the Treating Physician). The Treating Physicians are contracted by AH but also have to be registered with the WCB. WCA section 34(1) sets out the responsibilities of the Treating Physician when they are treating a workplace injury. The Treating Physician bills the cost of these treatments and reporting to WCB, not to AH. WCB Alberta also provides certain health services directly with its own resources, and also purchases services through direct contracting with service providers.

Each year WCB receives a large volume of medical reports from community doctors, specialists, diagnostic centres, therapists, and allied health services practitioners. These reports are related to new claims as well as those that are in case management. Injuries that result in lost time, must be accompanied by a doctor's report. In 2019 there were more than half a million medical reports related to the 178,346 cases administered (new claims and in case management), for an average of three reports per case administered. When considering only the new claims that have injuries resulting in lost time, and those that are in case management, the average number of medical reports per case would be approximately nine reports per case.



5.7.1 Medical Services Paid by WCB

WCB is the "first payer" for all medical and rehabilitation costs for a work-related injury in Alberta, regardless of who provides the service. This means all costs like treatment, reporting, disability benefits, training, etc. are paid directly by WCB from the Accident Fund.

The Medical Consultants and IME specialists have a direct contract for services with the WCB and their fees are paid by WCB. These transactions and the medical reports they produce do not enter the AH system. Medical Panel members are contracted by the AC and paid directly by the AC, which is funded by the Accident Fund.

In addition to medical advice and consultations, injured workers may also need surgeries and rehabilitation services to support their return-to-work. To do this, WCB contracts with provincially approved private surgical facilities. This allows WCB to purchase surgical care outside of AH to facilitate timely recovery and return-to-work. These facilities bill WCB directly using contracted fee schedules.

WCB also contracts with three return-to-work inter-disciplinary rehabilitation service providers: Millard Health, LifeMark, and CBI Health. All three providers deliver contracted assessments and programs paid directly by WCB at exactly the same contracted rates. Millard Health is owned and operated by WCB and, in addition to delivery of contracted services, Millard works to develop new programs like the recent COVID-19 program to address emerging care needs.

5.7.2 When a Compensation Decision is Changed

When a decision on a claim is changed as a result of a review or appeal, WCB, AH and AMA have a process for adjusting the costs as needed. All reporting sent to WCB is paid for by WCB, regardless of claim status. AH does not require reporting and does not pay a fee for reporting.

The worker's first visit to the physician is treated a bit differently when there is a change in decision, and it depends on what the worker reports to the doctor in the first visit.

- If the injury was reported as work related in the first visit to the doctor, reporting and treatment is submitted to the WCB. Later, if the injury is deemed not work related, WCB will advise the physician, who will submit any future billings to AH. For any payments already taken place, AH and WCB will adjust the payments accordingly. Note, WCB does not recover fees associated with the first visit or report.

- If the injury was reported as not work related in the first visit to the doctor, treatment billing is submitted to AH. Later, if the injury is deemed work related, the WCB and AH will make adjustments for billings, inclusive of the first visit and report.

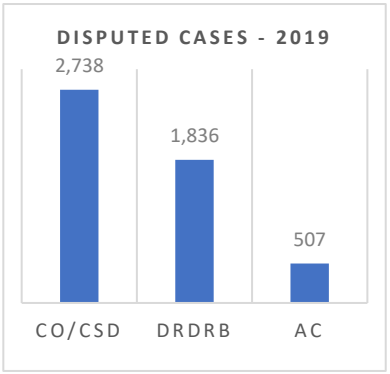
6. Dispute Resolution and Appeal – A Process Perspective

6.1 Introduction

This section of the report follows the experience of a claimant through the dispute resolution process. The description reflects the common experience of the worker and employer as they navigate through the process shown in Appendix 9. In doing so we discuss process efficiency and fairness perspectives and propose recommendations consistent with the purpose and scope of this review. The recommendations are aimed at addressing the root causes of the identified concerns. Our findings are based on a thorough analysis of facts and data collected by us and informed by the views expressed by those we interviewed. In some instances where data was not available, we have tried to illustrate with anecdotal examples. Our general assessment of Alberta's dispute resolution process is that while there are many strengths, there are aspects which do not align with the standards of a robust and efficient dispute resolution process and can be strengthened for better alignment with the principles of fairness. There are opportunities for gain in efficiency in the processing of disputes in the system agencies, and opportunities for avoidance of disputes as well.

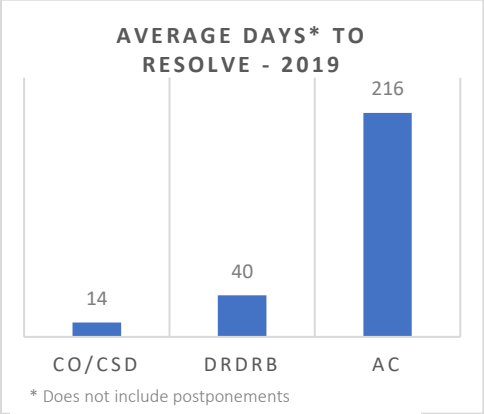
6.2 Overview

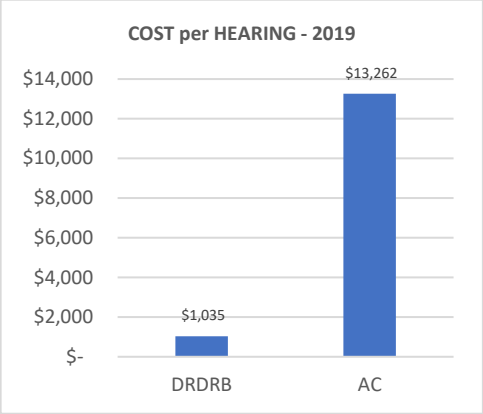
The WCA requires that after exhausting informal resolution approaches, a dispute must go through a WCB internal decision review process, and if the requestor is not satisfied, they may appeal to an external review body (AC). The first step is an informal review of the decision with the Claim Owner. The Claim Owner may consult their Supervisor who may review the decision and try to resolve the dispute. If a resolution is not achieved, the next step is a formal internal review performed by the DRDRB of the WCB. The final level is an appeal to the AC, which has appellate jurisdiction over decisions made by the DRDRB.



A worker or an employer can initiate a request for review when they disagree with a WCB decision. Workers usually request a review if they do not agree with the claim decision, the benefits awarded, return to work, or any such decision made by the WCB. Employers request a review when they do not agree with a worker's claim that has been accepted by the WCB (e.g. not a work-related injury), or when they disagree with an assessment made on their account. Based on 2019 data, workers initiated about 87% of all disputes while the employers initiated about 13% of all disputes.

The charts show statistics for the dispute resolution process in Alberta. Each dispute has one or more issues that required resolution. Data from 2019 shows that 2,738 disputes were initiated with the Claim Owner, out of which 1,836 (67% of total) were referred to the DRDRB. The remaining 33% were resolved by the Claim Owner. Of the disputes received by the DRDRB, 507 were appealed to the AC following a DRDRB decision. The cost per hearing and average days to resolve from intake to the decision date can be seen in the chart below, and reflect the fact that the more structured approach at each successive level requires more time and cost.





A conceptual model of the dispute resolution mechanism in Alberta's Workers' Compensation is illustrated on the next page. The schema shows the involvement of various entities and dispute resolution bodies, the key activities in their process, and approximate time taken to complete the activities. Detailed process charts are available in Appendices 9 to 11.

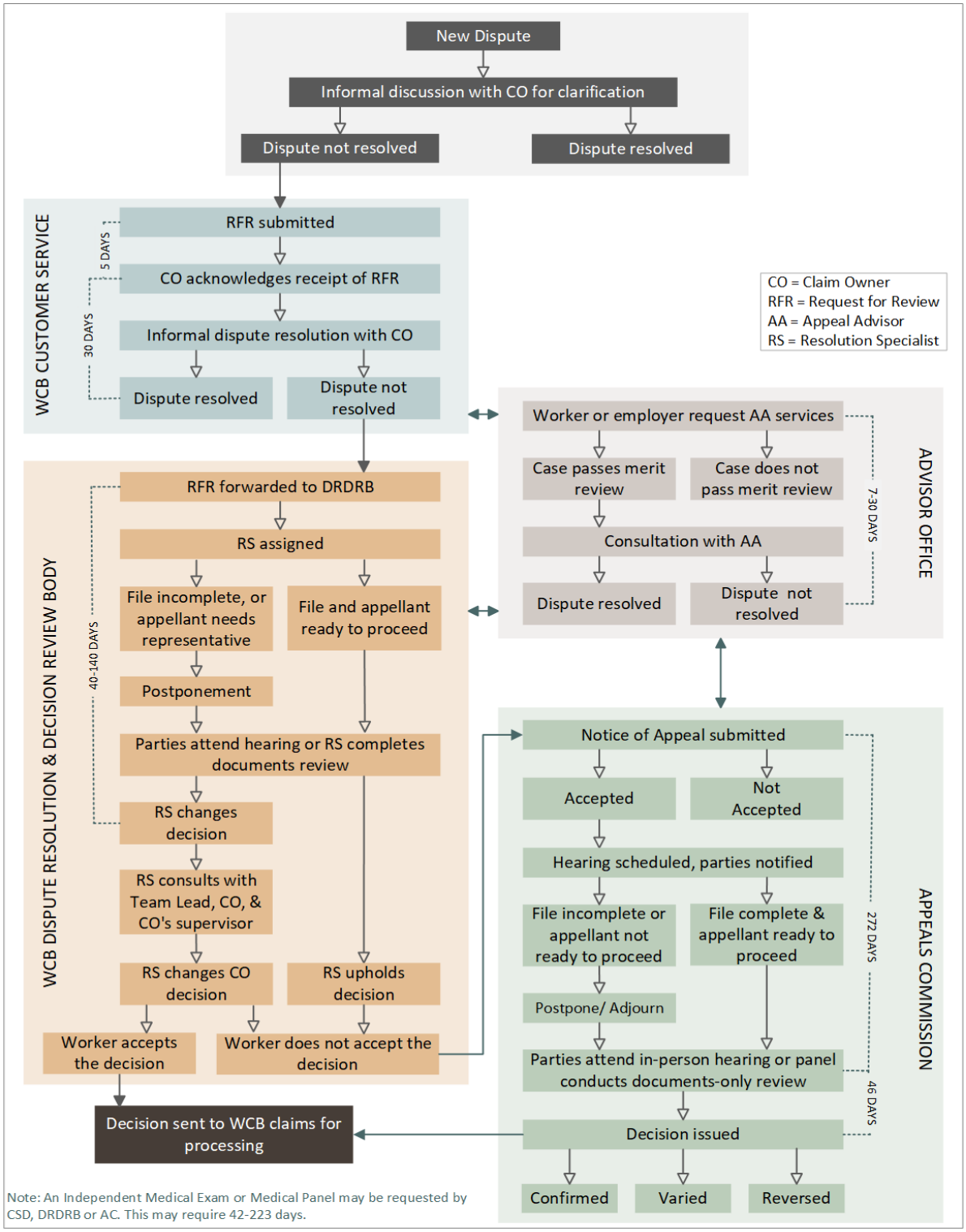


Figure 6.1: Dispute Resolution and Appeal Process in Alberta Workers' Compensation

6.3 Avoidance and Early Resolution

Disputes arise due to a variety of reasons, but they start when there is a disagreement with a decision made by a Claim Owner. On arriving at a decision, the Claim Owner writes a letter to the injured worker explaining their decision and the reasons for it. The decision letter instructs the worker to contact the Claim Owner should they have questions or require any clarification. The decision letter also informs the worker that they may request a review if they disagree with the decision. The information about the worker's option to request a review is on the last page of the decision letter. Some decision letters can be long, and a worker may not feel inclined to read the whole document. A reference to this information in the early part of the letter will be helpful. We noted that the decision letter does not provide information about supports (i.e. advice and representation) that a worker may require or request if they were to pursue a review.

WCB also encourages Claim Owners to call the worker before sending the decision letter, especially if the letter has an adverse decision for the worker. Helpful information is also available on the WCB website, as well as in the worker and employer handbooks, but these resources are not sent with the decision letter. If the worker is not satisfied with the decision or with the reasons stated, they must first call the Claim Owner. Workers have complained that reaching the Claim Owner can be challenging, as calls may not be returned in a timely manner i.e., within the 24-hr standard for turnaround set by the WCB, and when they are able to speak with the Claim Owner, their concerns may not always be fully addressed. At the time of the contact the Claim Owner may not know whether the worker will request a review of the decision, therefore information about advice and representation may not always be shared before completing the call.

Based on information gathered during our consultation, quite often the worker's initial contact with the Claim Owner is for seeking clarification on the often complex and difficult to understand decision letter. Common issues cited by Appeals Advisors with the decision letter include:

- Failing to clearly outline the reasons for the decision;
- Not relating the decision to a specific WCB operational policy ("policy");
- Referencing only the policy number without the details of the policy;
- Use of medical and legal language above the average worker's comprehension level, and
- Not explaining how medical opinions were weighed.

There are approximately 400 customer service staff in WCB who adjudicate the claims. Because of the number of decision letters written and the number of staff who write them, one would expect that the quality of the letters will vary. Only a small percentage of the letters (about 2% of claims) result in a disagreement. Those with a decision to deny the claim, as well as some approved claims, may escalate into a dispute. The variance in the quality of the letter can be due to a variety of factors such as staff turnover, workload, or individual skills. Additionally, the content of the letter varies depending on the type of adjudication decision, and the team where it is originating from. For example, the decision letter for claims relating to psychological injuries are more policy oriented and have less injury-specific details. This is a conscientious decision made by WCB to avoid incorporating details that may be re-traumatizing to the worker. To compensate for the lack of explanation in how the policy was applied, the Claim Owner will call the worker to explain the decision.

WCB has a quality assurance process which audits the quality of the decision letters. Based on the audit framework we received, the audit is focused on the quality of the decision and how it was arrived at. It does not assess the communication value of the decision letter to the same degree. WCB has a document called “All About Decision Letters - WCB Style for Decision Letters” which has extensive guidelines for how to write a high-quality decision letter. The style guide was in use until June 2021 but has since been revised. The audit tool has also been aligned with the new guidelines. The audit sampling is done after the fact, therefore WCB does not have controls built into the process to identify defects before the letter goes out. Claim Owners do have access to a Coaching Resource Team, mentors, and their supervisor for advice on the decision and the decision letter when they need it. Some supervisors review all letters with adverse decisions, while others only review those with a higher chance of being appealed, there is no standard across the teams. A robust quality-control environment around the decision letter, especially for decisions with a higher risk of being disputed, as well as using a continuous improvement approach with a focus on decision writing skills could reduce the number of requests for decision reviews.

Recommendation 7: Decision Letters

a) WCB revise the decision letter template to include information about supports available for workers and employers seeking clarification or dispute resolution.
b) WCB enhance the quality control of decision letters before they are sent out.
c) WCB enhance the assurance audit of decision letters to include factors that improve the communication value of the letter, in alignment with the decision letter style guide.
d) WCB adopt a continuous improvement approach to decision writing skills with feedback and re-training.

Clear information about supports available, and where to find them, to the workers is a desirable service on its own. We do not see any conflict in the WCB providing neutral information about the availability of the Appeals Advisor service. For example, the decision letter could have the link to the Request for Review page of the WCB website, as well as a link to the Advisors Office website.

Of the 33% of disputes that are resolved at CSD, it is estimated by them that up to about three quarters (24% of total disputes) are resolved by explaining the decision letter (no change in decision). This may indicate that the quality of the decision letter is a determinant of whether the worker or employer will dispute the letter. Achieving a higher level of consistency with defined standards for the communication value of decision letters may reduce the likelihood of a dispute escalating.

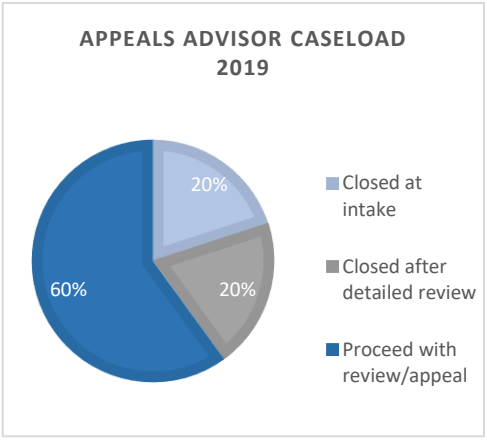
As with any skill, continuous training and upgrading is important for maintaining the quality of decision writing. WCB could adopt a rigorous quality management process within its "passport" system for training of new staff, especially in light of the high staff turnover experienced in the recent past.

Upfront investment in the quality of the decision letter and supports available to the worker in the early stages will pay off in reduction of more expensive downstream dispute resolution processes as well as in the volume of calls to the customer contact centre.

When the decision letter is explained by the Claim Owner or someone else, the worker has a better chance of understanding the decision and may choose not to pursue the issue further. If the worker is not satisfied with the answer from the Claim Owner, they may request a review by the DRDRB. If the worker does not have a representative or advisor at this point, they may be informed by the Claim Owner about

their options. However, oftentimes workers do not have a representative until the DRDRB has assigned the case to a Resolution Specialist. The worker is advised by the Resolution Specialist of their option to have a representative, and then they may request the services of a system funded Appeals Advisor, hire a fee-for-service professional (private advocate) for advice and representation during the dispute, or choose to represent themselves through the process.

When the worker requests the services of an Appeals Advisor, their file undergoes a pre-assignment review (in place since April 2021) before the request can be accepted for representation. The purpose of the pre-assignment review is to identify appeal issues, file paperwork to protect any potential appeal deadlines, identify issues that may be premature, and identify issues that are outside the scope of the Advisors Office. If the worker is accepted for representation, the Appeals Advisor will explain the decision letter to the worker in a manner that they can understand, and they will also explain the potential challenges and possible outcomes if the worker was to proceed with an appeal. Four out of ten workers understand and accept the Appeals Advisor's advice to proceed or not with formal dispute resolution. Some of the workers who do not accept the Appeals Advisor's explanation may choose to continue their appeal, either as self-represented or with other representation. Data from 2019 indicates that approximately 20% of the requests that the Appeals Advisors received were closed at intake based on a merit review that was in place at the time, and another 20% were closed after a detailed review of the file by explaining the decision letter and the possible outcomes of an appeal. Therefore, 40% of their intakes were closed or resolved before contacting the WCB. The Appeals Advisors receive about 60% of the total disputes that get initiated, therefore implying that 24% of all disputes that got initiated were resolved by helping the appellant understand the decision letter and the potential outcome of an appeal.



The practice of conducting a review before accepting a case for representation is also followed by the fee-for-service private representatives (e.g., advocates, lawyers), although the purpose is more to catch any red flags from the risk perspective. Based on conversations with private representatives, their process may include a basic level of review and explanation of the decision letter, so most of the cases that they accept are quite likely to proceed to formal dispute resolution in WCB. Considering the disputes that are self-

represented or represented by fee-for-service professionals, it would be reasonable to assume that the percentage of disputes that could possibly be resolved before initiating a formal process would be about the same as with the Appeals Advisors.

Recommendation 8: The Appeals Commission redefine the role of the system funded Appeals Advisor to extend their advisory role in the early stages of dispute i.e. disagreement with the decision letter.

Avoidance of a dispute is the most desirable outcome, while still supporting and facilitating the worker's and employer's right to appeal. The option of getting advice or explanation from a neutral third party in the early stage is more desirable and better perceived by the worker than the idea of asking for an explanation from the Claim Owner. Owing to their advisory role which requires skills particularly suited for rationalizing and explaining complex ideas the Appeals Advisor may be well suited for the role. A further enhancement to the service may include a referral to a specialized service for particularly vulnerable workers, e.g. those with complex medical/mental health needs and without immediate family supports available.

The Advisors Office as an early point of access to the appeals process for claim decision related complaints would be akin to the Fairness Review Office being the first point of contact for fair treatment related complaints. This enhancement to the Appeals Advisor role would not only improve customer service for the appellant, but could also help them avoid more expensive and likely, less desirable alternatives. As our findings in a later part of this report indicates, the Appeal Advisors enjoy a good reputation among employers, workers, and the WCB staff and therefore would likely be well accepted in this role. Financial analysis also indicates that any resource requirements driven by the new role can be balanced by the savings derived through reduction in escalation.

In our consultations, all the stakeholders expressed support for Appeals Advisors taking a greater role in the early stages of disagreement, while keeping intact the Claim Owner's relationship with the worker.

6.4 Review by Customer Services Division

The worker, the employer, or their representative will contact the original decision maker with a Request for Review (RFR) and/or a Resolution Submission, which outlines the issues and their desired outcome. This begins the informal dispute resolution process with the Claim Owner, which is intended to be a collaborative process between the Claim Owner and the worker/representative to understand each other's position, and to be understood.

WCB standard requires that the Claim Owner acknowledge the receipt of a Resolution Submission within 5 days, and if an agreement is reached then address the issues within 30 days. If a resolution is not reached, and a Request for Review has been received by the Claim Owner then the request must be sent to the DRDRB within 14 days of receiving the request. The experience of the representatives has been that after sending the acknowledgement letter, the Claim Owner waits until the last few days to start addressing the issues, with no communication in between. An alternative may be that the interim duration could be better utilized with a collaborative approach right from the beginning. For example, in the acknowledgement letter, the Claim Owner could share information such as what approach they will be taking to resolve the issue, what timelines to expect, and what further information might be required. While this may require some additional time upfront by the Claim Owner, it could potentially save time later in the process. This would allow the Appeals Advisor to provide better customer service to the worker by sharing that information and being more responsive. In the absence of this exchange the worker only receives vague instructions for next steps.

Appeals Advisor's suggest that sharing planned actions in the acknowledgement letter would result in a more value-based interaction between the Claim Owner and the representative, both in arriving at a mutually agreeable resolution, and in implementing the resolution. Knowing what approach the Claim Owner may take, the representative could share their ideas or suggest alternatives if they had information relevant to the approach. For example, if the Claim Owner was going to request a medical report from the Treating Physician, the Appeals Advisor might be able to propose further information to obtain from the Treating Physician at the same time, or the Appeals Advisor might suggest an alternative to requesting the report, such as more direct communication with the Treating Physician if the case warranted it.

Going by the experience of the worker and employer representatives, it appears that the Claim Owner begins the work required to resolve the issue after a few weeks have elapsed, and then there is a dash to the finish. Appeals Advisors give examples of situations where a Claim Owner has acted (e.g., requested a

medical record or made a decision) based on incorrect assumptions. More than one representative narrated their experience of discovering that the claim decision was made without completing the record, that is without acquiring all the evidence, and the decision is changed after the missing information is acquired. This happens more frequently with medical information, for example the Claim Owner not discussing the case with the worker's Treating Physician or not waiting for a medical report to arrive. These procedural lapses create distrust in the adjudication process, add to the cost of dispute resolution, and also cause stress and inconvenience to the worker. In the opinion of the representatives, improved collaboration between the Claim Owner and the representative at an early stage would resolve issues earlier and increase efficiencies on both sides.

Recommendation 9: WCB structure the 30-day duration for CSD resolution and implementation to be utilized in value adding collaborative actions.

The Claim Owner's key role is to adjudicate claims that come through intake and to manage the ongoing needs of the claim. Given the number of Claim Owners and the number of requests for review that are submitted, it is reasonable to conclude that addressing a dispute is not a common occurrence in a Claim Owner's experience. Therefore, more robust guidelines for resolving disputes efficiently and effectively would be desirable.

A key guidance for the Claim Owner could be to create a collaborative environment with the appellant and their representative early in the process. Information sharing is a vital attribute of a collaborative approach in dispute resolution. For example, discussing the path forward or seeking input in the resolution approach with the representative, soon after the initial acknowledgement letter is sent. The intent should be to collaboratively make incremental progress throughout the time until the dispute is resolved and the agreed resolution implemented. Adopting a more collaborative approach will enable disputes to be resolved quicker and with less overall effort.

6.5 Review by the DRDRB

The process with the DRDRB is triggered if a resolution is not reached between the Claim Owner and the worker or employer. The DRDRB will assign a Resolution Specialist to conduct the review of the decision made by the Claim Owner.

The Resolution Specialist may also provide a Preliminary Consultation Review to the Claim Owner. This service requires providing guidance to the Claim Owner when they are reconsidering their own decision at the request of the worker. A Resolution Specialist who provided a Preliminary Consultation Review is not assigned to conduct a decision review for the same case. However, a case may be assigned to the same Resolution Specialist who has recently reviewed a different issue on the same claim.

6.6 Review Process and Hearing

The process followed in the DRDRB is for the Resolution Specialist to study the case file and first confirm that a decision has been made on the issue by the Claim Owner. If a decision has not been formalized, the Resolution Specialist will send the file back to CSD and ask them to complete their process. If all the required material is present in the file, the Resolution Specialist will contact the appellant for an initial conversation to gain their perspective on the issues under review. The Resolution Specialist also explains the review process and allows the appellant to select a resolution approach, i.e., a documentary review or a hearing. The hearing may be in-person, by telephone, or by video conference. If the worker does not state a preference, the Resolution Specialist selects the format by considering the complexity of the case. For documentary reviews, the appellant has two weeks to submit further information pertinent to the review, for a hearing they may submit new information up to the hearing date. Anything submitted will be shared with the other party if they are participating, and they will have two weeks to respond. Once all submissions are received, the Resolution Specialist completes a file review and decides on the issue(s) under review. A concern shared by the representatives regarding submissions is that the DRDRB does not have a policy on the submission process. Unlike the AC, which allows the initiating party to make the last submission or respond to a submission made by the other party, the DRDRB does not follow a similar policy. In some cases it has allowed the non-initiating party to have the last submission.

If a hearing is required or requested, the Resolution Specialist decides the date and sends the invitation to the worker and the employer. The employer may not be invited if the relationship with the worker is severed or strained, but they are kept informed. The worker is allowed to bring their representative and an approved support person, such as a family member. The Resolution Specialist may also invite the Claim Owner and/or their Supervisor to the hearing, but this is an exception.

The DRDRB hearings are scheduled for an hour and are rarely longer, regardless of the number of issues to be resolved. Most worker representatives do not think this is a sufficient amount of time, particularly for more complex cases. The DRDRB hearing is chaired by the Resolution Specialist, but the proceedings are

not formal. No other DRDRB members attend the hearing or participate in the document review. The hearing is an opportunity to discuss the issues and expectations, and to resolve the issue collaboratively. Each party is allowed to share their position relative to the issues in the Request for Review. This provides the worker with an avenue for expressing their grievances to the Resolution Specialist and what they are seeking for an outcome. They may also gain a better understanding of how the Resolution Specialist will resolve the issues. A concern expressed by the representatives is that some Resolution Specialists are not able to control the conversation and sometimes the worker and employer begin arguing with each other.

Representatives state that they have observed that on some occasions the Resolution Specialist is not prepared for the hearing and will disclose this to the worker and their representative. These hearings are not rescheduled, instead the Resolution Specialist will take the information from the hearing and conduct their review. The concern is that the hearing proceeds even when the Resolution Specialist is not prepared. This approach does not support collaborative resolution when only one party is able to share their position and ideas for resolving the issues. Based on our information gathered, some Resolution Specialists use the hearing as their means to understand the background of the dispute and expectations of the parties, following which they review the file. This is consistent with DRDRB procedure 3.1-16 which states the parameters for participation in an Alternate Dispute Resolution by a Resolution Specialist – "they will not express opinion, advice, advocate or decide in the meeting". However, considering that the meeting between the Resolution Specialist and worker/employer is called a hearing, this approach may be counter-intuitive to best practices in dispute resolution, particularly as the parties are attending the hearing with a different expectation of the outcome of the hearing.

The service standard at the DRDRB is to make a decision within 40 days of a referral. Data indicates that the DRDRB met that standard 88% of the time in 2019. This statistic does not include the days that a file is postponed. Data from WCB shows that when postponement happens, it adds on average 100 days to the review, however this extension is not included in the reported statistics. The data also indicates that about 55% of the DRDRB issues (approx. 40% of total disputed cases) that are postponed at least once, are represented by an Appeals Advisor or a paid representative (about half each). WCB tracks delays caused by postponement of hearings and the type of representation, but does not track who requested the postponement, or for what reason. The most common cause of postponement, as informed by WCB is when a review is assigned to a Resolution Specialist, but the worker does not yet have a professional representative. In this situation, the worker is given time to find a representative, and the file is put on hold. Once the formalities for representation are complete, the representative will inform the Resolution

Specialist that they are ready to proceed. The status of the file is not changed at that time, but only when the hearing is complete.

Postponements also arise when an issue is sent back to the Claim Owner as 'premature', or when more time is required to gather additional medical information or other evidence. About 10% of disputes are returned to the Claim Owner as "premature", and there is a policy to guide that decision. The Claim Owner will re-adjudicate these cases, and if the worker still does not agree with the decision, they will follow-up with the DRDRB. But sometimes, disputes are delayed in the DRDRB without a clear reason. As an example, in one particular case, an Appeals Advisor sent a resolution memo for a documentary review in June 2020, and despite enquiries to the DRDRB, the decision was not made until February 2021. To the best of anyone's knowledge, there were no extenuating circumstances in this case, and no reasons were given by the DRDRB for the delay.

The additional days due to postponement are significant and would provide a more accurate picture of the total duration of the DRDRB review. If days postponed were accounted for, the average time to complete a DRDRB review would exceed 100 days. This is too long from the perspective of the worker, and well over the service standard, and as such should be addressed with appropriate measures. Improving the worker's awareness of the availability of supports, enhancing collaboration between the Resolution Specialist and worker representative, and improving process clarity, may be potential approaches to reduce days lost in postponement.

Recommendation 10:

a) WCB address the issues that cause high rates of postponement, and target to eliminate postponement occurring due to avoidable reasons.

b) WCB report the actual days for completion of reviews to reflect the real-life experience of workers and employers, and manage performance based on that metric.

A longer dispute resolution process is costlier for the entire worker compensation system. Any delay in decisions made by the WCB has an impact on the worker, possibly even delaying their recovery and return to work. Therefore, it is imperative that postponements and delays be avoided. Claim Owners, Appeals Advisors, and Resolution Specialists should be proactive in their approach to identify factors and scenarios that can delay the resolution timeframe. They should advise the worker and the employers on what they could do to mitigate those circumstances.

One of the common reasons is that the worker does not have a legal or other representative to advise them through the process. This would be mitigated by our earlier recommendation regarding information in the decision letter, and by making the Appeals Office as a support available to them.

The fact that only 33% of DRDRB reviews are represented by funded Appeals Advisors and about 40% reviews are self-represented indicates that the current approach for sharing information about supports available to the worker could be improved. Some of the 60% reviews that have representation, get it only after starting the DRDRB process, resulting in delays of over 100 days.

Data from 2019 shows that 1,370 issues were postponed by an average of about 100 days each. Accounting for the fact that one appeal may have multiple issues, we estimate that approximately 90,000 days per year are lost in postponement of DRDRB disputes. The economic cost and the cost on the worker's well-being due to this delay are impossible to estimate.

6.7 The DRDRB Decision

The DRDRB follows a collaborative/participative model for their own decision-making in which, if needed, the Resolution Specialist can consult with others in the value chain, including the Claim Owner who made the decision. The Resolution Specialist makes a decision on the issues a few days after the hearing. Until this point, the Resolution Specialist assigned to the review has not interacted with Claim Owner in the process of making their own decision, except if requesting missing information on the file. The process for

upholding the decision is straight-forward, the Resolution Specialist only has to make this known to the parties.

However, the process is different if the Resolution Specialist is changing the Claim Owner's original decision. In the DRDRB's participative model, when changing the original decision, a Resolution Specialist is expected to discuss it with their own Team Lead, and arrive at a consensus with the Claim Owner, and if needed, with their Supervisor before finalizing their decision. There is a perception among the representatives that unless there is an obvious or compelling reason which can be easily argued, the Resolution Specialist finds it easier to accept the original decision knowing that the injured worker still has the option to appeal. The Resolution Specialist may still change the original decision if the Claim Owner or their supervisor do not agree with them, but the Resolution Specialist has to formally record the outcome as changed without agreement. Data shows that the DRDRB upholds about 80% of the decisions made by the Claim Owner, only about 20% of decisions are changed with or without agreement with the Claim Owner. Compared to other jurisdictions the proportion of decisions upheld at the review level is highest in Alberta as shown in the chart for jurisdictional comparison.

The reasons we were given by WCB for adopting this approach for the DRDRB includes, firstly to ensure that any review capitalizes on opportunities for coaching and learning for those involved; and secondly to ensure that those responsible for implementing and managing the decision understand the new decision and agree with it.

The consensus approach for making decisions in the DRDRB is not a documented requirement but it is inherent in the DRDRB's participatory decision-making model. The conversations and interactions that the Resolution Specialist has within DRDRB and with CSD after the hearing in the decision phase are not documented in the claim file. The Resolution Specialist only outlines the process of arriving at the decision in the decision memo. The DRDRB does not perform quality audits of the decision-making process or the decision memos.

Recommendation 11:

a) Define a clear governance and organizational model for the DRDRB to create an independent and arms-length operation from CSD. Delink the DRDRB role from any quality assurance or learning outcomes for CSD.

b) Redefine the decision-making model of the DRDRB to better align with expectations of a statutory decision review.

The various concerns discussed in the previous sections such as, decision review involving the original decision maker, undocumented case discussions, informal hearings, and consensus-based decision making with the original decision maker, reflect a complex and in some stakeholder's view a business model that is not transparent. The distrust among stakeholders in relation to the DRDRB emanate from these reasons, and therefore can be assuaged when they see demonstrable change. Improvement in the trust factor should result in higher rates of resolution within the WCB.

The recommended changes are critical to ensure an independent review body and restore trust among stakeholders in this important aspect of the system's dispute resolution model. DRDRB's participative decision-making model has been a source of speculation and misunderstanding among system stakeholders because it does not conform to the common expectations of a statutory dispute resolution process. The staffing approach, reporting relationship, and Resolution Specialist's supplementary role as advisors to Claim Owners give credence to speculations about lack of independence. The statistics related to the decision outcomes at the DRDRB and the AC further compound the perceptions of bias. In summary, the WCB could repurpose the DRDRB to reflect a higher level of independence, and to address the misperceptions that have continued to dominate the narrative around the DRDRB.

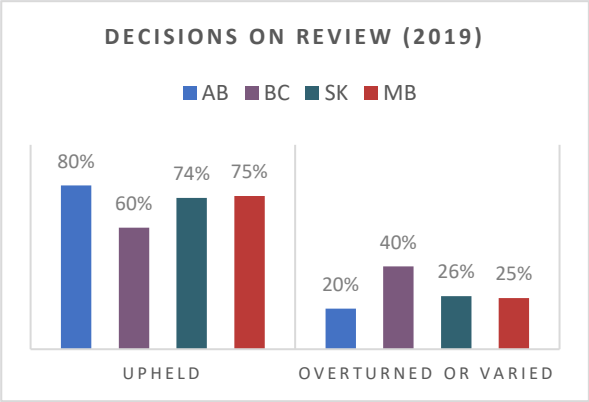
We suggest that the DRDRB's decision-making model align with an arbitration approach for alternate dispute resolution. All the other jurisdictions we studied have a decision review body, which although internal to the Board, operates at an arm length from the claims group and makes decisions completely independently.

When claimants do not have confidence in the process, they do not accept the decision. This results in avoidable escalation to a more expensive and time-consuming next level. Increasing the trust and transparency of the DRDRB process will most likely decrease the number of disputes escalating to the more resource intensive process in the Appeal Commission because more workers and employers will be satisfied with the DRDRB process.

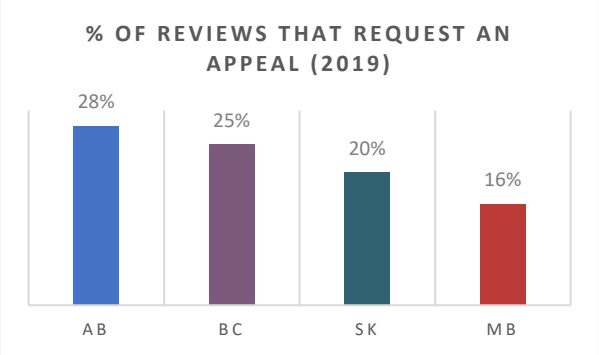
Format of Decision Reviews in Other Jurisdictions

Alberta is the only province to utilize a collaborative approach for decision review (RS and DRDRB). BC, SK, MB, and ON have internal review bodies which operate independently from primary adjudication. They do not consult with or seek agreement from the Claim Owner in making their decision.

As shown in the chart below, Alberta has the lowest rate of decisions changed at the review level.



Additionally, Alberta has the highest proportion of reviews that proceed to request an appeal.



6.8 Interpretation of Policy and differences in DRDRB and AC decisions

The consulting team sought to understand the specific types of decisions that may cause disputes. Operational data to validate these specific examples is not available, however, without reason to refute the sources of this information, these examples may demonstrate the variance in decisions made by the DRDRB and the AC. We were given examples by the worker and employer representatives where policies are applied differently by the WCB for certain types of medical conditions. For example, Claim Owners are

more likely to reject hearing loss claims if they do not see a specific pattern (the "notch") in the audiogram of the injured worker. While this is not written in policy (policy 03-01 part 2 Application 5), but for a claim to be approved by the adjudicator, the "notch" must appear in the audiogram, because Claim Owners are applying a procedure to make an adjudication decision, not the policy. We were told by the same sources that, based on medical science, the pattern may not always be conspicuous as it changes naturally due to aging. Many workers are reportedly turned down for hearing loss benefits by the DRDRB, but if they continue to the AC, it is quite likely that they will receive the benefit. Data to track the decision on specific cases from the Claim Owner to the AC is not available, but according to the Appeals Advisor's experience in recent years, the AC is more likely to allow those claims and overturn the DRDRB decisions.

The prevalence of psychological injuries and mental health conditions arising out of physical injuries have risen in recent years. Policy is not clear on how to establish causation for these injuries, resulting in subjective decision making at the adjudication stage. The subjectivity often weighs against the injured worker's claim. For example, for acceptance of a Chronic Onset Psychological Injury (policy 03-01 part 2 application 6 pg. 5) all criteria listed in the policy must be met, including one which states, "…the work related events are excessive and unusual in comparison to normal pressures and tensions experienced by the average worker in similar occupation." This leaves room for subjectivity as a definition is not provided for what is "excessive and unusual in comparison to normal pressures" or what is "an average worker", consequently decisions may vary between the DRDRB and the AC. Stakeholders contend that interpretation of policy should allow room for the variability that is seen in psychological and mental health conditions, and causations that can differ from one individual to another.

Another frequent issue where the DRDRB is more likely to disallow a claim, is earnings loss payment (ELP 65/ELP reduction/ELP retirement). When an injured worker reaches the age of 65 their wage compensation is significantly reduced with the assumption that they would have retired. However, many clients intended to work past their retirement age and therefore want their compensation to continue at the appropriate rate. But the worker has to prove that they would have kept working. We were informed that the DRDRB is more likely to refuse the request for adjustment, whereas the AC is more likely to award the compensation adjustment, based on the same evidence.

Data shows that about a third of requests for review by the DRDRB are related to additional entitlements, many of which relate to Housekeeping/Home Maintenance Allowance (HKA/HMA) (policy 04-10 part 2 app 3). It is the Claim Owner's responsibility to investigate a workers' restrictions and entitlements (e.g.,

permanent work restrictions), and include these necessities in their entitlement. Worker Advisors have a perception that Claim Owners are not taking an objective approach when calculating these entitlements, because these benefits are not being issued unless the worker or the representative asks for them. When the worker later discovers that they did not get their entitlement, they file an appeal. Some of these instances may be due to human error or lack of knowledge. Improving the adjudication on the basis of the intent of the policies will reduce appeals and related administration costs in the system, and in the long run improve trust.

WCB states that the determination of permanent restrictions takes time (the worker has to reach medical plateau) and therefore the administration of the Housekeeping/Home Maintenance Allowance is usually done retroactively. In this case, the Claim Owner could inform the worker of the process and the conditions for reimbursement (e.g., submitting evidence in the form of receipts) in the decision letter. WCB could enable the Claim Owner to settle the benefits proactively when receipts are submitted, not through the decision review process.

An example from the employer's perspective demonstrates the fine balance that the adjudicators have to maintain in fairness and objectivity. Employer representatives stated during the consultation that lately a common reason for employer-initiated appeals was that claims were being accepted without sufficiently establishing causation (the injury was work related). They contend that adjudicators were using lack of evidence as a substitute for benefit of doubt, although WCB's Policy 01-03 Benefit of Doubt, clearly excludes it. An example of such a case included a shift-worker's claim being accepted for an injury that happened on a non-working day.

Recommendation 12: Clarify the interpretation and application of policies where there are frequent differences between the Claim Owner, DRDRB, and AC decisions based on analysis of trends.

Differences in interpretation and application of policy can occur in everyday adjudication. WCB could put systems in place to identify trends and patterns of difference in interpretation that result in avoidable disagreements and disputes. Claim Owners could have a clearer understanding of the guidelines for adjudication. For example, Claim Owners could demonstrate a greater appreciation of the difference between a procedure and a policy in practice, and that adjudication must be based on policy not procedure, as demonstrated in claims related to hearing loss.

Workers today are much better informed of their rights and entitlements due to the availability of information and resources, both from the WCB and from other sources such as their employers, unions, and independent advisors. WCB could work with the assumption that any defects in adjudication or administration of benefits will have a greater cost in the long term because of the cost of dispute resolution. Placing further controls and quality assurance measures that improve the quality of adjudication upfront would benefit the process.

In addition, there could be ongoing training and awareness for Claim Owners on principles of adjudication, weighing of evidence, managing bias, and worker's rights and entitlements. The WCB could require every Claim Owner to update their training in the foundational principles of worker compensation within a reasonable time frame. As well, WCB's commitment to these principles should be continuously reinforced through appropriate messaging from senior leaders.

Identifying Policy Improvements in Other Jurisdictions

British Columbia

WSBC has a designated Quality Assurance team which audits the processes and decisions made by the customer services division, the Review Division, and their external appeals body (tribunal). The team analyzes rends in disputes and decisions and communicate their findings. In recent years, the Review Office Quality Assurance team noticed an increase in permanent disability claims. Further investigation revealed these claims were predominantly related to claims with mental health components. Discovering this trend led to alterations in how psychological claims are adjudicated.

Manitoba

In MB's Review Office, all Review Officers receive the same training that is given to Claim Owners as a means for staying well-informed on processes in the adjudication function.

6.9 New Evidence

Resolution Specialists only review decisions made by a Claim Owner. If during the review any new evidence comes forward that is relevant to the issue being reviewed and is very likely to change the adjudication decision, the DRDRB sends the file back to the Claim Owner for re-adjudication. If after re-adjudication the worker is still not satisfied, then the issue is reviewed by the DRDRB.

It is reasonable for the DRDRB to ask the Claim Owner to re-adjudicate if the information presented is related to a decision that is not disputed. The request for review is specific to a decision made on a specific date, if the new information is material to the decision in dispute, then the DRDRB could have the power to make a decision based on the new evidence under appropriate conditions.

Recommendation 13: Review the practice of DRDRB sending back a case for re-adjudication when new evidence is related to a decision in dispute.

If an adjudication decision exists, and the Request for Review is valid, then new evidence should be applied to the review and a ruling made by the DRDRB. Sending the case back to the Claim Owner should only be allowed when the Resolution Specialist is convinced that their own decision would not be favourable to the worker's interest. Based on the materiality of the decision and if they were re-adjudicating in favour of the appellant then there would be no need to return the dispute to the Claim Owner. This will promote forward momentum on the dispute, instead of redirecting the worker in a potential loop.

The Fairness Principle requires that the process for dispute resolution is straight forward, efficient, and moves towards resolution. Sending back a dispute not only affects the timeliness of the decision, it also creates the possibility of aggravating or further complicating a dispute.

New Evidence in Other Jurisdictions

British Columbia

New evidence is considered by the Review Officer, it is only returned to the Claim Owner if they believe they would change their decision if provided with the new evidence. 17.83% of reviews are returned to the Claim Owner in BC.

Saskatchewan

New evidence is always returned to the Claim Owner. If the decision is not changed by the adjudicator, then the case returns for a review on a priority basis. 7.37% of cases are returned to the Claim Owner in Saskatchewan.

Manitoba

The Review Officer will return new evidence to the Claim Owner only if it is of a substantive nature that will undoubtedly change the decision. 17.73% of reviews are returned to the Claim Owner in Manitoba.

Decision Reviews in Other Jurisdictions

British Columbia

The Review Division operates independently within WSBC. Review Officers individually conduct documents-based reviews that include formal and informal inquiry. In 2019, the Review Office decided on 10,572 reviews, averaging 127 days to complete a review. Their 71 fulltime Review Officers each made an average of 149 decisions. (Note: BC is the only jurisdiction to rule on occupational health and safety (OHS) matters, which accounts for the higher number of reviews they receive).

Saskatchewan

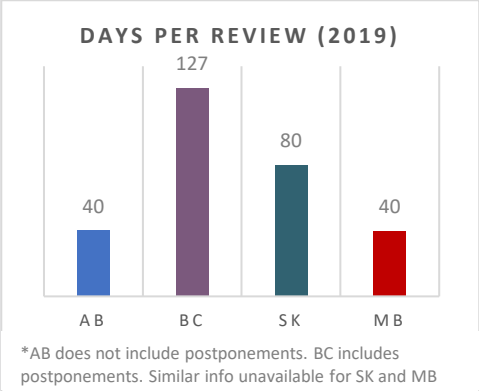
WCB's Appeals Department conducts the first formal review on Claim Owner decisions. Appeals Officers perform documents-based reviews, contacting the parties involved as needed, and potentially organizing a meeting at the appellant's request. In 2019, the Appeals Department decided on 1,017 appeals, and averaged 80 days to complete an appeal. Their 9 full-time Appeals Officers made an average of 113 decisions each.

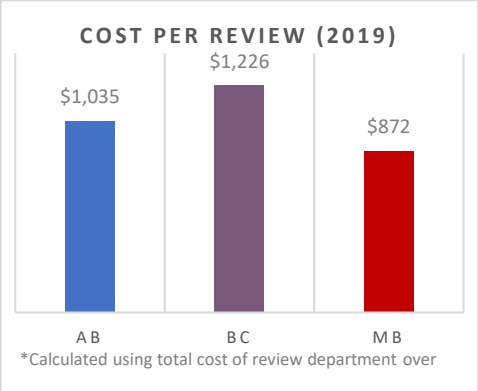
Manitoba

In WCBMB's Review Office, the Review Officers operate independently and have access to medical advice if needed. All Review Officers receive the same training that is given to Claim Owners as a means for staying well-informed on process changes within the adjudication function. Ten Review Officers processed 1,237 reviews in 2019 averaging about 12 reviews each.

Ontario

The ASD conducts internal appeals for WSIB. Similar to Alberta, these appeals can be in either documentary or hearing format. However, unlike Alberta, the ASD is a formal level of appeal, independent of primary adjudication.





6.10 The Appeals Commission

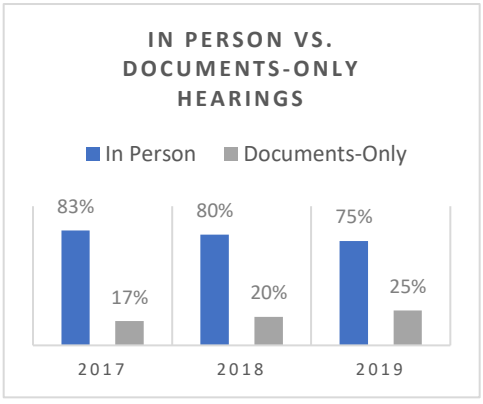
If a worker or employer is not satisfied with the decision of the DRDRB, they may file an appeal by submitting a Notice of Appeal (NoA) to the AC. The AC has an appellate jurisdiction on all disputes related to the WCA, with very few exceptions which are specified in the Act. In relation to claim disputes the AC accepts three types of appeals:

- Time Extension, when the appellant is requesting a relaxation of the statutory time limit for appeals;
- Initial Appeal, when the appellant is requesting a review of a decision made by the DRDRB; and
- Reconsideration of Decision, when the appellant is requesting a review of a decision made by the AC.

The flowchart showing the case management process in the AC is available in Appendix 11. Once a Notice of Appeal is received, an Appeals Officer is assigned who becomes the single point of contact for the appellant and serves as an AC case manager. The responsibility of the Appeals Officer includes coordinating with other parts of the AC to schedule a pre-hearing meeting if required, preparing and distributing the Appeals Document Package (ADP), answering any ongoing enquiries from the related parties, and scheduling the appeal hearing. A Scheduling Committee and the Vice Chairs decide which three Commissioners will hear the appeal, who will Chair the panel, and the first hearing date.

6.11 The Hearing

The AC allows appeals to be completed either through documents-only review, or with a hearing which can be in-person or virtual (phone, video-conference). The appellant chooses their preferred format. In 2019, 75% of the hearings held by the Commission were in-person hearings, while the remaining 25% were documents-only review. The documents-only hearings are primarily related to requests for time extensions, and re-considerations of AC decisions. The Appeals Commission is a quasi-judicial tribunal and its hearings are much like a court of law but less formal. One of the three Commissioners chairs the hearing and follows protocols based on the Rules of Procedure established by the Chief Appeals Commissioner. The in-person hearings can be completed in half-day or full-day formats depending on the complexity of the case and the number of issues to be decided. Hearings can also be adjourned at the request of one of the parties or if new evidence is presented requiring more time to study.



The hearings are scheduled three to four months from the date the panel is appointed. The primary consideration for the scheduling date is to allow time for preparation and logistics to the parties as well as the AC. Availability of the Commissioners and meeting resources do not seem to affect the hearing date. The AC reports that the average number of days from the date the Notice of Appeal is accepted to the first hearing date for all types of appeals, including initial appeal, request for time extensions, and reconsiderations, is 170 days as reported in the AC's 2019 annual report. The actual duration can vary from three months for time extension type appeals to over two years for more complex appeals. The annual report states that an additional 46 days on average is required for writing the decision after the hearing. About 30% of decisions have taken more than 30 days to write. Our analysis of AC data from 2019 indicates that the average gap between the hearing date and the Commissioner's decision date is about 39 days (for a total of 209 days from intake to decision). Longer durations between the hearing and the decision date may be due to the need for a decision meeting between the Commissioners or just due to the complexity of the decision.

The duration from intake to the first hearing date reported by the AC does not include the days that are lost due to postponement (at the request of a party to the dispute) or adjournment (decided by the Chair during the hearing), or if the appellant did not accept the first hearing date offered by the AC. When these days are included, our analysis of AC data shows that the average duration from intake to the hearing date for initial appeals is 272 days and to decision date is 310 days indicating that the average days in postponement is about 100 days. The AC sets its performance target for intake to first hearing date at 150 days, and from hearing to decision date at 30 days, for a total of 180 days. The experience of individual appellants can vary significantly. For example, about 20% of appeals required more than 1 year, and a very small number (likely with MP) required more than 2 years.

MP requests from the AC are rare (approximately seven in the year) however, most of these are requested during the hearing which usually occurs three to four months after intake. Knowing that a MP can add several months to the process, this practice could be reviewed to identify factors to flag the potential for a MP earlier.

The AC began doing virtual hearings due to Covid-19 restrictions and plans to continue offering virtual hearings. They have found that there may not be significant time savings between an in-person and virtual hearing. However, the latter may save on travel time and costs for the participants and the workers compensation system.

Recommendation 14:

a) The AC take appropriate steps to reduce the time between intake and hearing date, and between hearing and decision date for appeals that have fewer or less complex issues, to within service standards.
b) The AC address the issues that cause high rates of postponement. Target to eliminate postponement (or adjournment) occurring due to avoidable reasons.
c) The AC report the average duration for each type of appeal so the duration reflects the real experience of appellants.

Data from 2019 shows that 73% of the appeals have only 1 issue, and 25% have between 2 to 5 issues, while the remaining 2% may have more. Scheduling of the hearing three to four months in the future may be reasonable in many cases considering that some workers and employers will need that time to organize their information. However, assessing the need for how much time may be needed, based on factors such as the completeness of the file before scheduling may be more efficient than using 3-4 months as a standard practice. AC does not prioritize one appeal over another in order to maintain equity and to avoid any perception of favour. However, scheduling less-complex appeals with shorter interval to the hearing date as a matter of policy will allow better resource utilization, improve customer service and also improve overall average duration.

The AC has the highest rate of in-person hearing and the highest cost per hearing in comparison to the other four jurisdictions as the charts in the jurisdictional scan show. The AC could conduct more documents-only hearing and use smaller panels for less complex appeals, like those being used in other jurisdictions. This approach would not only reduce per unit cost but also help shorten the timeframe. WCA section 13.1(2) allows the Chief Appeals Commissioner to appoint panels of two commissioners.

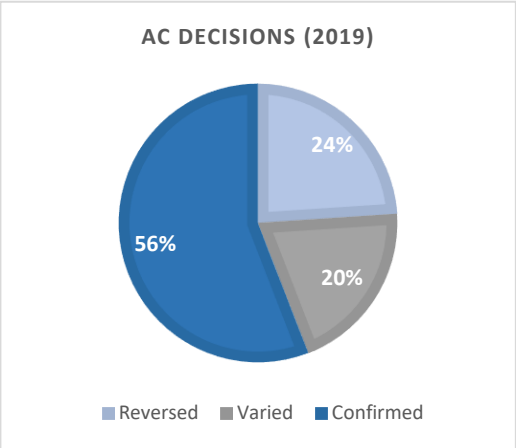
AC should also analyze the reasons for delays in writing the decision and address those reasons to increase timeliness. For example, scheduling the decision meetings earlier than 39 days on average would make decision writing easier while the memory of the hearing is still fresh. Also, available technologies could be utilized to support efficient decision writing.

Days in postponement is a cost to the system and any avoidable delays must be mitigated. Data shows approximately 100 days in postponement on the average, for a total of about 50,000 days in postponement per year. These delays have a potential cost to the worker and the employer. AC could target a percentage reduction over the next few years with better process management i.e., proactively identifying and mitigating factors that can cause delay in the process.

Changing reporting standards to include actual duration as experienced by the appellant would reflect the reality, and increase performance management based on the real metric, and is more transparent. At a minimum, a clarification is warranted regarding the duration currently being reported.

6.12 Appeal Commission Decisions

In 2019 the AC reversed the decision made by the DRDRB in 24% of the appeals, confirmed the decision made by the DRDRB in 56% of the appeals, and varied the decision in 20% of them. Recalling that the DRDRB confirms over 80% of the decisions made by the Claim Owner, which usually are the ones that proceed to the AC, the numbers indicate that about half of those are reversed or varied by the AC. Compared to other jurisdictions Alberta has the highest percentage of decisions reversed or varied at the appeal tribunal level.



The difference in the rulings of the DRDRB and the AC can be attributed to reasons such as new evidence being presented, not applying the same weighting, or not applying policy in the same way. Applying different weighting of medical and non-medical evidence accounted for 95% of the decisions that were reversed by the AC.

On another note, in 56% of the appeals the AC confirmed the decisions made by the DRDRB. While this is an optimistic statistic, the fact that they were appealed may suggest an opportunity to improve how to communicate the facts and evidence to appellants in the early stages of the resolution process. This supports our earlier recommendation for more clarity, counselling, and support for the worker in the early stages of the dispute to help avoid escalation.

6.13 New Evidence

The AC has jurisdiction on decisions made by a review body. It does not adjudicate on a new matter related to a claim. The AC accepts new evidence presented in the hearing or before, provided it is related to the issues that are in the appeal. When new evidence is not relevant to an issue in the appeal, but may affect another adjudication decision, the AC sends the case back to the WCB for re-adjudication. Occasionally, the AC will put the appeal on hold until the matter has been addressed by the Claim Owner. When a case is referred back to the WCB, it may or may not affect the compensation decision in appeal. If the worker is not satisfied with the decision, they will start a new appeal, while during this time the issues in the original Notice of Appeal are put on hold by the AC.

If the new evidence is related to an issue of appeal, the AC returns the case to the WCB for further adjudication, in order to avoid being a decision maker of first instance and removing the party's right to appeal. In certain circumstances a case in appeal may also be returned to the DRDRB for reconsideration if there is new evidence or if the AC determines there was a procedural defect. The AC refers back about 17% of appeals to the DRDRB for reconsideration. The exact reasons are not tracked, but generally speaking they are because the AC determines there was a significant defect in the DRDRB's review process, or the new evidence could affect the DRDRB's decision. In such cases, when the DRDRB completes the reconsideration, the claimant may still want to proceed with the appeal if they are not satisfied with the new decision, and the issue will be added to the appeal. This causes a delay in the resolution of the original issues. AC is the final decision maker and therefore it makes sense to send the case to the WCB/ DRDRB for reconsideration so that the worker does not run out of options. However, the redirection could be avoided if there is no jurisdictional issue and if the AC would have ruled in favour of the worker in this case. With the recent amendments to the Workers' Compensation Act that took effect in early 2021, the AC has some flexibility in how it processes requests for reconsideration of its own decision, and therefore the option of making a ruling in the above situation may be more feasible now.

New Evidence in Other Jurisdictions

British Columbia, Manitoba, Ontario

Accept new evidence during appeals without returning the case to the review or claims department provided it pertains to the issues being appealed.

Saskatchewan

Requires that any new evidence be reconsidered by the most recent decision-maker prior to hearing the appeal by the Board Appeal Tribunal.

Appeals in Other Jurisdictions

British Columbia

BC's Workers' Compensation Appeal Tribunal is an external and final level of appeal for WSBC decisions. The Chair determines the format of the appeal (live hearing or documents-based) and assigns 1 to 7 Vice Chairs to sit on an appeal panel. WCAT decided on 2,307 appeals in 2019, averaging 253 days from receiving the request for appeal to delivering the decision.

Saskatchewan

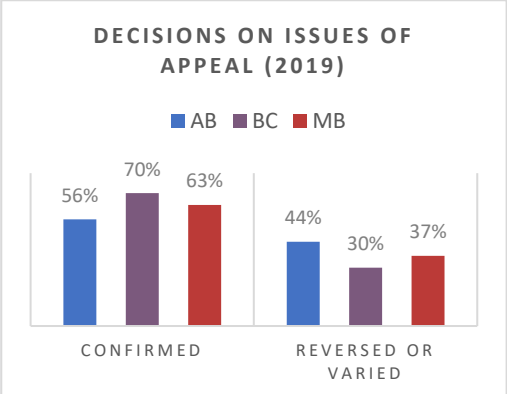
SK WCB is the only jurisdiction that does not have an external appeal process. The governance board of the WCB provides the Appeal Tribunal, which forms a 3-person panel to decide on appeals. In 2019 they decided on 231 appeals and averaged 130 days to render their decision.

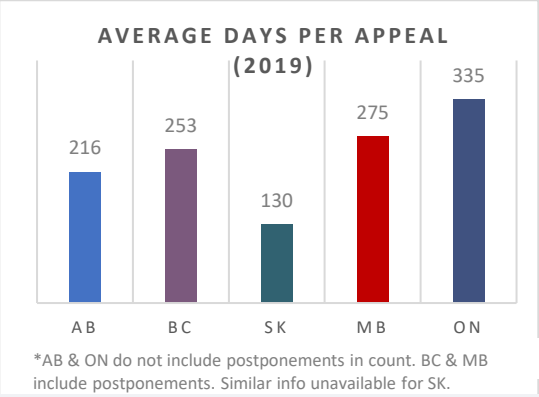
Manitoba

Manitoba's Appeal Commission operates almost identically to Alberta's Appeals Commission. They are the only other jurisdiction to give the appellant a choice in the format of their appeal (live hearing or documents-based), and their appeals are decided by a 3-person panel of Appeal Commissioners. In 2019, the Appeal Commission decided on 158 appeals, and averaged 196 days to complete an appeal. Their target for delivering a decision following the hearing is 60 days, in 2019 they average 10.7 days.

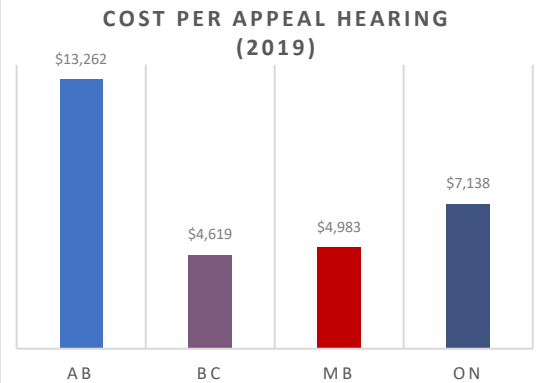
Ontario

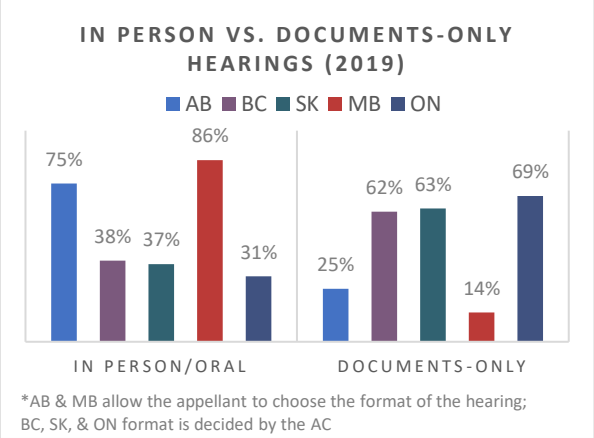
Ontario's Workplace Safety and Insurance Appeals Tribunal is the final, external level of appeal for WSIB disputes. Appeals are typically decided on by a single Vice-Chair, though there may also be a 3 to 5-member panel for more complex cases. Appeals are conducted through either live hearings or documents review, with the format being decided by WSIAT. In 2019, WSIAT decided on 2,685 appeals, taking an average of 335 days per appeal.





Appeals in Other Jurisdictions Contd...





*Cost per hearing is affected by the format of the hearing and the composition of the panel. BC and ON panels are predominantly single member, with some having three, but can be up to seven panelists in BC. AB, SK, and MB appeals are typically heard by 3-person panels. AB and MB have high proportion of in-person hearing and therefore associated cost of reimbursement.

7. Medical Opinion and Medical Panel – A Process Perspective

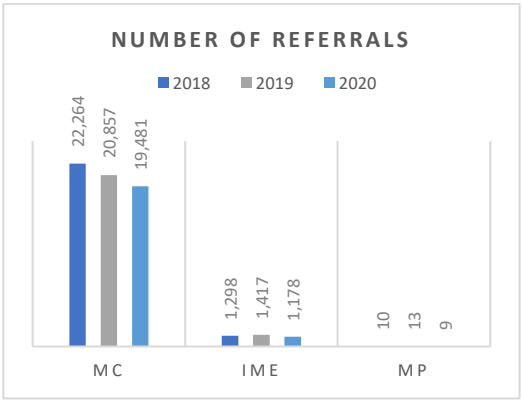
7.1 Introduction

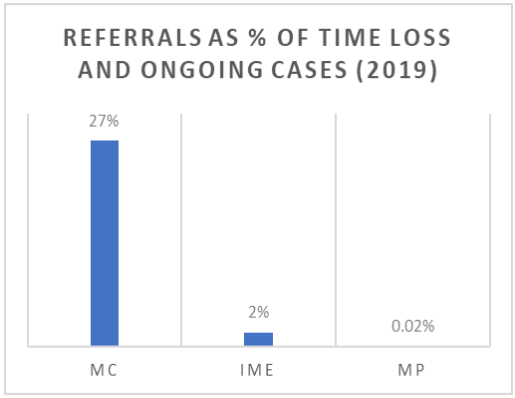
In this section of the report, we adopt a process view of the medical opinions and medical panel in Alberta WCS. We trace the journey of a medical disagreement starting with a disagreement between the claim owner and the treating physician, its escalation to Medical Consultant and IME opinions, and in the rare cases to the Medical Panel. We identify the concerns in the process and provide recommendations to address them. Our general assessment of Alberta's medical dispute resolution process is appreciative as one will infer from the details that follow, although we have identified a few areas where avoidance and process improvement can increase efficiency and provide cost savings.

7.2 Medical Decisions in WCB Claim Adjudication

Claim adjudication is a responsibility of the Claim Owner. In order to make objective and sound decisions during adjudication and ongoing claim management, the Claim Owner can request opinions from medical professionals. Establishing the work-related causation of the injury is necessary for the injury to be compensable. Other questions of a medical nature that Claim Owners are faced with relate to treatment, recovery and fitness to work. In Alberta, the Claim Owner can access three different types of professional medical reviews/input to assist in their decision making. The Claim Owner can request a medical opinion from a Medical Consultant who is internal to the WCB. If needed, the Claim Owner can request an IME, where a qualified physician, external to the WCB, examines and reports on the worker's condition. A third and final option exists with the Medical Panels, which is a quasi-judicial body that has the authority to make final and binding decisions in relation to medical disputes.

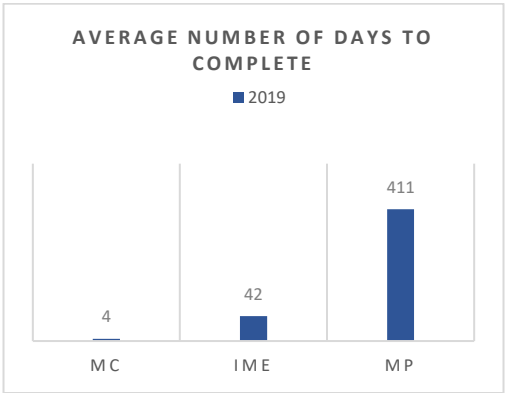
Each of the three medical reviews/input are structured to be independent from the claim adjudication function, and their purpose and service delivery processes are also different from each other. The Medical Consultants are practicing community physicians contracted by the WCB to provide independent medical opinions based on documentary review of the worker's medical information. The IMEs are performed by practicing medical specialists selected from a roster of qualified physicians, which is maintained by WCB's Medical Services department. Both these resources can provide crucial information to the Claim Owner to support their adjudication. The MP is an external tribunal of qualified medical professionals that makes final and binding decisions on medical matters when the WCB is unable to reach a consensus on a worker's medical condition.

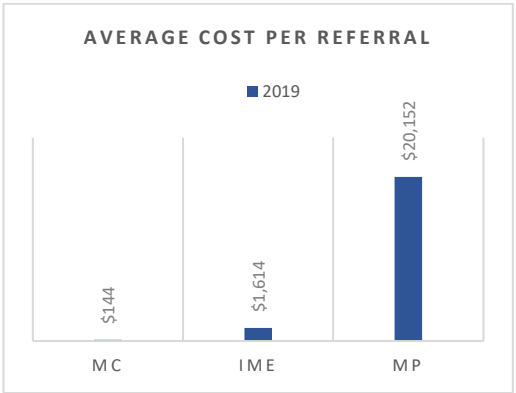




Medical consultations primarily occur on time loss claims from the current year's intake and those from previous years that are in case management. The data in the charts show the relative volume of cases, and metrics indicating utilization, days to completion, and cost for each type of service. As one may conclude, the decreasing proportion of referrals in each subsequent stage of escalation is a healthy sign. The difference in the count of referrals between Medical Consultants and IME in the year may be used as a proxy indicator of the number of claims with medical questions that were resolved without escalating to the next step. For example, in 2019 there were 20,857 Medical Consultant referrals but only 1,417 IMEs, indicating there were about 19,440 claims for which medical questions were resolved with the Medical Consultant's opinion alone.

The charts below show that the average days to completion and average cost per referral increases as the dispute moves through the system, which underscores the benefits of avoiding escalation. We also compared these indicators with other jurisdictions that have similar services as shown in the j-scan box a few pages later. The comparison indicates that WCB Alberta is consistent or better than the other jurisdictions in all these measures.





The figure on the next page is a conceptual model of the medical dispute resolution process in Alberta's workers' compensation. The schema shows the involvement of various service providers such as the Medical Consultant, IME and the MP, the key activities in their process, and approximate time taken to complete the activities.

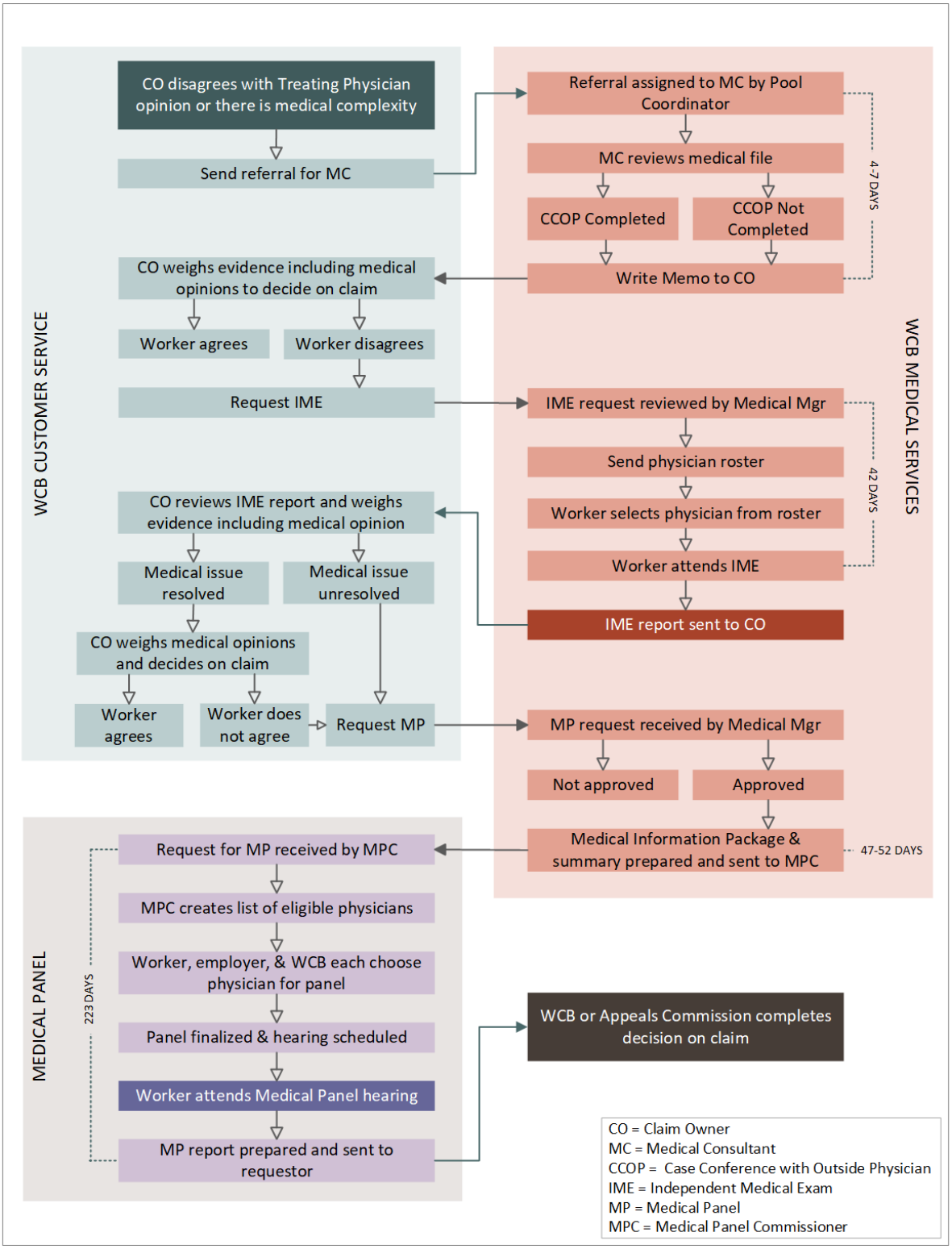


Figure 7.1: Medical Opinions and Medical Panel Processes in Alberta Workers' Compensation

7.3 Medical Consultants

Of all the new claims that the WCB receives each year (129,851 in 2019), about 77% (100,000) are dealt with within days since there is no lost time for the worker due to the injury. The remaining new claims, about 30,000, that do result in lost time, are managed by Claim Owners. Every new "time loss claim" requires medical information from the physician who treated the worker after the accident – the Treating Physician. Upon reviewing the medical information and the facts in the worker's file, the Claim Owner can adjudicate the claim. However, if the worker's condition is complex and recovery is not proceeding as expected, or the Claim Owner needs an independent opinion on the injured worker's medical condition, they may ask for further medical tests, supporting information, or clarification from a medical professional. Medical Consultants provide this independent medical opinion.

Medical consultants are health care professionals contracted by the WCB to provide independent medical opinions upon request by the Claim Owner. Medical Consultants are trained in worker compensation related topics such as causation, clinical impairment, functional capacity assessment, and fitness to work. For the most part, the claims that are referred to the Medical Consultant are time loss claims and require active care or case management beyond 4-8 weeks.

The Medical Consultants do not examine the injured worker. They provide independent medical opinions to the Claim Owner based on documentary review of the injured worker's medical records, test results and knowledge/research of the medical issues involved. However, their opinions have a bearing on the medical adjudication process, and therefore on the compensation decision, should the Claim Owner choose to accept the Medical Consultant's opinion over the Treating Physician's opinion. As such, their opinion must have clarity and must engender a level of confidence upon which the Claim Owner can adjudicate a claim.

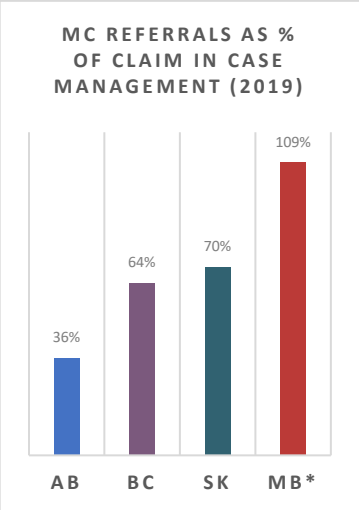
In addition to providing medical opinions, the Medical Consultants help identify when the available medical information on a worker's injury is insufficient for forming an accurate opinion on their medical condition and provide options for obtaining the missing information. It is the responsibility of the Medical Consultant to help the Claim Owner understand an injured worker's injury, illness, possible treatments, recovery times, and outcomes. This includes helping Claim Owners develop return to work options for the injured worker that account for functional limitations and necessary accommodations in their workplace.

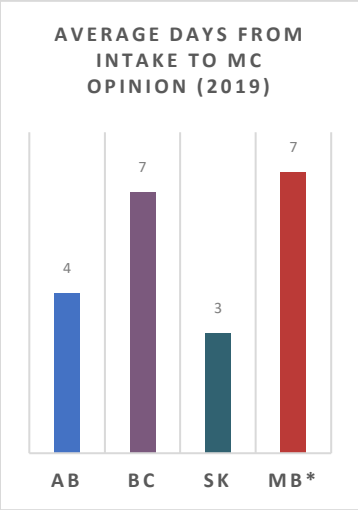
In 2019 the Medical Consultants provided opinions on 20,857 referrals, of which approximately 55% (11,470) were for time loss claims that opened in the same year (based on Medical Consultant Quality

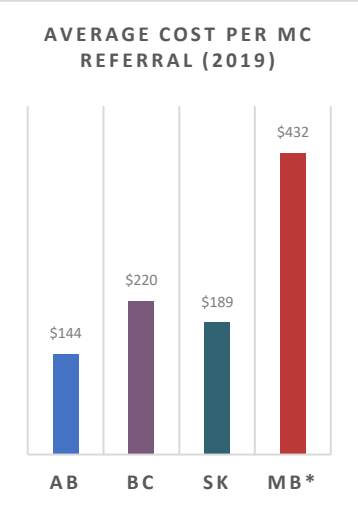
Assurance Report of 2019). The remaining were for claims that were opened in prior years. There were 30,000 new time loss claims in 2019 of which 38% required a Medical Consultant referral. WCB reports that 80% of Medical Consultant referrals are completed within 4 days and 95% are completed within 5 days. As the information below shows, WCB Alberta compares favourably against other provincial systems in the indicators for Medical Consultant performance.

Medical Consultants in Other Jurisdictions

All the provincial systems (BC, SK, MN, and ON) utilize medical professionals for providing independent medical opinions to Claim Owners. The majority of service providers are practicing physicians who do part-time contract work with the respective WCBs. The Medical Consultants in BC, SK, and ON provide their opinions based on documents only review, without examining the injured worker. In MB, the Medical Consultants may examine the injured worker if they need to. WCBMB has seen a significant decrease in IMEs and MPs, which are currently almost non-existent, over the past decade since allowing their Medical Consultants to physically examine the worker.







*MB includes cost and time for completing physical exam when needed.

Claims in Case Management implies new time loss claims and those from previous years that are in case management.

Average Cost for Alberta is the average of invoices from Medical Consultants, for other provinces total salary budget (including management) per referral.

7.4 Emergence of a Medical Dispute

The conditions that define a medical disagreement are set in section 46.3(10) of the WCA. Medical disagreements occur when there are differing medical opinions between medical practitioners (for example, the Treating Physician and the Medical Consultant) whose opinions carry the same weight on a medical issue which is substantial and material to the claim. This means both physicians have access to the same information, have the same or similar qualifications, and their information is related to the same time frame of care.

A medical dispute occurs when the worker or an employer does not agree with the Claim Owner's weighing of differing medical opinions on their injury, recovery, line of treatment, ability to work, etc. Only the Claim Owner may determine if a medical disagreement exists and they may consult their supervisor to confirm their finding. WCB Business Procedure 40.13 – Conflict of Medical Opinion, provides a framework for deciding if a medical disagreement exists as described in the Act. The procedure requires the Claim Owner to first weigh the opinions from the Treating Physician that is on file. If the information from the Treating Physician is inconclusive then the Claim Owner is required to ask for the information from the Treating Physician. If upon weighing the opinions expressed by the Treating Physician(s), the Claim Owner determines that a conflict of opinion exists or additional clarification is needed, then they are required to initiate contact with the Treating Physician and then attempt to resolve the conflict.

If the medical disagreement cannot be resolved between the Claim Owner and the Treating Physician, then the Claim Owner should seek an independent opinion from the Medical Consultant. The procedure stipulates that in such a situation, the Claim Owner can ask the Medical Consultant to resolve the conflict of medical opinion. The procedure also states that when weighing the opinions, the medical opinion by a physician who has examined the injured worker carries more weight than the opinion based on documentary review, such as that completed by the Medical Consultant. As part of the conflict resolution process, the Medical Consultant can contact the Treating Physician and try to facilitate a conversation that may lead to an agreement or convergence of opinions.

However, in reality when the Claim Owner disagrees with the opinion of the Treating Physician or needs additional information from the Treating Physician, the Claim Owner rarely calls the Treating Physician. Contact with the Treating Physician is almost always done by the Medical Consultant. We know from consultations done with community physicians for the Medical Consultant Quality Assurance Study done by Engage First Management Consultants in 2019, that the Treating Physicians do not encourage direct

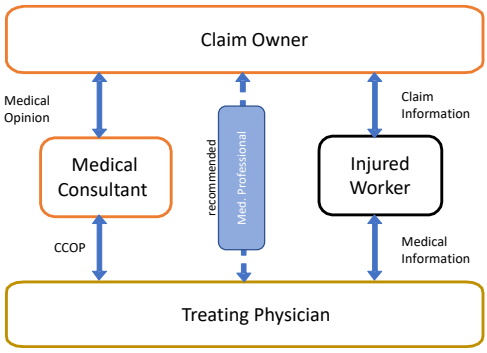
contact from the Claim Owner for clinical discussions. To accommodate this expectation, WCB prefers that Claim Owners refer the case to the Medical Consultant when they need a clarification or additional information from the Treating Physician. In order to follow up with the Treating Physician, the Medical Consultant will inevitably provide a medical opinion. Data from WCB indicates that 20-25% of referrals to Medical Consultant are only for calls to the Treating Physician. This is not necessarily efficient. Having more than one opinion creates the possibility of having differing medical opinions. Had the Claim Owner contacted the Treating Physician directly, they may have been able to adjudicate without needing a Medical Consultant opinion, and the possibility of a difference of opinion would not exist.

An avoidance approach would encourage the collection of all of the information needed for adjudication by the Claim Owner without a referral to the Medical Consultant. The Medical Consultant opinion would only be required if there is a deficiency in the medical opinion of the Treating Physician, and if the Treating Physician does not change their opinion. A few days spent in acquiring the clarification is likely more efficient than seeking a new opinion, which has a potential to create a disagreement and a costlier delay in the decision.

When there are two different opinions, and the Claim Owner takes the Medical Consultant's opinion over that of the Treating Physician, then it is more likely that the worker will challenge the decision. The Claim Owner may then request an IME, or the worker may request a review of the decision. Data indicates that among the decisions that were reversed by the AC, 75% were due to a difference in the weighing of evidence and 20% were due to a difference in the weighing of medical opinions.

Recommendation 15: WCB facilitate one to one follow up between the Treating Physician and the Claim Owner, with the support of a medical professional, when only a clarification or additional information on a medical opinion is needed.

The essence of WCB procedure 40.13 is that escalation is to be avoided. If the information from the Treating Physician is complete and sufficient for adjudication, then a decision could be made without the need for a Medical Consultant opinion. As in every WCB system there is a level of trust placed on the professional opinion of the Treating Physician and others who have examined the worker.



WCB could enable contact between the Claim Owner and Treating Physician, when simple clarification of medical opinion or additional medical information is required, so that unintended escalation is avoided.

In addition to the Claim Owners themselves contacting the Treating Physician, which is not very desirable when the conversation is of a clinical nature, there are two other options for facilitating the contact between the Claim Owner and Treating Physician. The first option could be to ask the Clinical Consultant (who as a WCB staff assists the Claim Owner on medical matters) to complete the information request or to participate in the 'Case Conference with Outside Physician' with the Treating Physician. The other option is to ask the Medical Consultant to assess the information request without offering a new medical opinion. The latter seems to be more difficult given the nature of the Medical Consultant's role in the system, but the first option could be further explored for feasibility.

Any time there is more than one medical opinion, there is a finite possibility of a difference of opinion. Putting in place this recommendation will streamline the Medical Consultant referral to only those that arise from a real difference of opinion.

7.5 Why Medical Disagreements Get Escalated

Should a medical disagreement remain after a Medical Consultant's opinion, the Claim Owner may request an IME. In the rare cases when after receiving an IME report, the Claim Owner determines that there is still an unresolved difference in medical opinion which is substantial and relevant to the claim, then a MP may be requested. There are three likely scenarios when a medical disagreement may escalate to an IME or a MP:

(a) There is a medical complexity that requires a highly specialized medical expertise that is not available within the WCB.

(b) The Claim Owner does not find the opinions of the Medical Consultant or Treating Physician to be conclusive or consistent and needs further clarification to weigh the evidence in order to adjudicate. In this case, the opinion of the Medical Consultant and the Treating Physician are similar, but the Claim Owner needs more clarity. The reasons why a Claim Owner may not be satisfied with either opinion can vary, but possible factors include the quality of the medical opinion, or the sheer complexity of the opinions. The opinion from the Medical Consultant must be convincing enough to enable adjudication.

(c) The opinion of the Medical Consultant and the Treating Physician are different, and they have not resolved the difference of medical opinion collaboratively. In this situation, if the Claim Owner accepts the Medical Consultant's opinion over that of the Treating Physician, there is likely to be a dispute because the worker will be concerned that their Treating Physician's opinion was disregarded. The worker may then request a decision review. As well, if the Claim Owner needs more clarity on either opinion, then they may ask for clarification or seek an IME.

7.6 Addressing Quality Factors to Reduce Medical Disputes

We examined some of the key contributors to quality along the value chain of a medical decision on a claim. The figure on the next page illustrates the possible causes that may eventually lead to a dispute. The opinion provided by the Medical Consultant is a key piece of information for the Claim Owner's adjudication. It helps the Claim Owner determine entitlement, treatment planning, and potentially the worker's return to work. The quality of the Medical Consultant's opinion and the memo written by them is a factor in the Claim Owner's decision and how that decision is conveyed to the worker in the Claim Owner's decision letter.

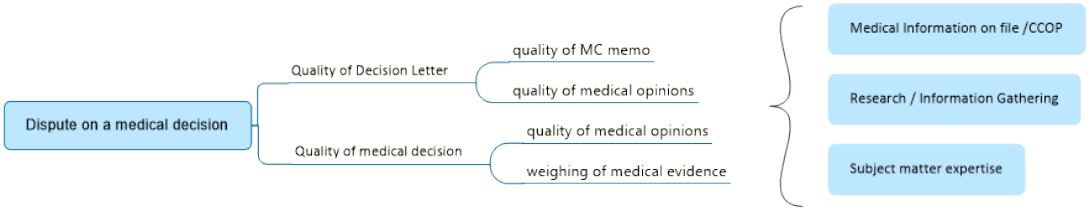


Figure 7.2: Factors causing dispute related to a medical decision.

We present our analysis of the key contributing factors and how they can be managed better to reduce the possibility of disputes.

7.6.1 Case Conference with Outside Physician Increases the Chance of Consensus

It is not surprising that, some times, two medical professionals arrive at different opinions when reviewing the same information. However, when the Medical Consultant arrives at a different opinion but does not consult with the Treating Physician before expressing their opinion to the Claim Owner, they miss an opportunity of reaching a consensus.

One important expectation of the Medical Consultant, especially when their opinion is different from the Treating Physician's opinion, is that they discuss their findings directly with the injured workers' Treating Physician, a process that is referred to inside WCB as Case Conference with Outside Physician (CCOP). The CCOP gives the Treating Physician the opportunity to provide their perspective based on their medical knowledge, familiarity with the injury of the worker, and the worker's medical history. The Medical Consultants can gain valuable understanding by listening to how the Treating Physician came to their medical conclusions.

Talking to the Treating Physician increases the chances of consensus when there is a difference in opinion. A survey conducted in 2019 by Engage First Management Consultants, indicated that when the Medical Consultant and Treating Physician talk to each other, differences in opinions are resolved 60% of the time, avoiding the need for an IME or MP. Therefore, a CCOP is highly desirable, especially when there is any disagreement or deviation between the professional opinions of the Medical Consultant and the Treating Physician. The same survey indicated that, when disagreeing with the medical opinion of the Treating Physician, only 40% of Medical Consultants reported contacting the Treating Physician.

The 2019 study had also discovered that "consensus" is a relative term. There were complaints from the Treating Physicians who were consulted in the study that sometimes a consensus is presumed even if

there is no agreement after a long discussion. After the CCOP, the Medical Consultant will write a letter to the Treating Physician summarizing the conversation. The letter concludes by saying that if they do not hear back from the Treating Physician within seven days, they will assume there is agreement.

Contacting the Treating Physician can be challenging. There are logistical considerations which must be considered, such as the availability of both physicians at a specific time, the Treating Physician having access to the medical record at the time of the call, and the willingness of the physicians to participate. Often injured workers move closer to their families who may be in another city or another province. These factors affect the likelihood of the call occurring and the quality of the interaction.

Over the last few years WCB has implemented a new system that facilitates the CCOP and makes it easier to complete the calls by scheduling and sharing information in advance. As a result, the CCOP contact rate has increased from 34% in 2018 to 64% in 2020. During the same time period, the percentage of Medical Consultant referrals for which a CCOP was completed has increased from 23% to 32%.

When there is no consensus between the Medical Consultant and the Treating Physician, the likelihood that an IME will be required, or that the adjudication decision will be disputed, increases. Data from 2019 shows that 62% of DRDRB reviews have a Medical Consultant referral (although this does not imply that the medical opinion was material to the review), and about 64% of those that needed one would have had a CCOP. Given the proportion of medical disputes, a higher CCOP completion may be desirable to mitigate escalation of disagreements.

At present, consultation with the Treating Physician is a discretionary practice. Some Claim Owners do ask that a CCOP be completed when the Medical Consultant is providing a different opinion, but this is not a common practice as indicated by the percentage of completed referrals. While their incentive plan accommodates for the wait time for completing a CCOP, the fact that a CCOP was conducted is not a factor in the quality audit of their memo. The quality of the CCOP when it is completed is not audited either. The Medical Consultant has some discretion in contacting the Treating Physician, even when the opinions are different and when the Medical Consultant's opinion could potentially change the outcome of the case. After weighing the evidence the Claim Owner can accept the Medical Consultant's opinion, even if the Medical Consultant has provided an opinion without a CCOP.

As well, the process of weighing one opinion over another can be subjective, although Procedure 40.13 does state that an opinion based on a physical examination has more weight than one based on documentary review.

Recommendation 16: WCB require a mandatory contact between the Treating Physician and the Medical Consultant when the Medical Consultant is providing a medical opinion that is different from that of the Treating Physician.

Data indicates that CCOPs are effective in resolving differences of medical of opinion. WCB has been successful in increasing the CCOP completion rate, and this may have contributed to the decreased number of IMEs, and MPs over the last three years. WCB could target to increase CCOP rate to 100% when there is a difference of opinion between the Medical Consultant and Treating Physician.

Requiring a mandatory CCOP as part of informal dispute resolution for medical disputes will have advantages. The WCB operational policy/procedure could have a more authoritative directive to require a CCOP whenever the Medical Consultant differs in their medical opinion with the Treating Physician, and especially when the Claim Owner is accepting the differing opinion of the Medical Consultant. This would increase the chances of consensus before adjudication and decrease the risk of disputes.

With information from the CCOP to back-up their decision, Claim Owners may be able to better explain their decisions in the decision letter and to the worker.

Medical Consultant – Treating Physician Contact in Other Jurisdictions

BC

Recognizing the value of communication between Medical Consultants and Treating Physicians for preventing and settling medical disputes, WSBC recently initiated a program where the Medical Consultant must discuss all claims that have been open for greater than eight weeks with the Treating Physician. To support Treating Physician participation, WSBC has been working to improve their billing process for these consultations.

MB

WCB Manitoba's Medical Advisors play an active role in resolving medical differences in opinion through contact with the Treating Physician. As they may be in direct contact with the injured worker, the Medical Advisor shares all exam notes with the Treating Physician to increase transparency and give each party access to equal information.

7.6.2 Quality of the Memo

The Medical Consultants provide their advice either verbally in a short consultation with the Claim Owner, or in the form of a written memo. The memo is judged for quality assurance by its clarity and the quality of the medical information, including the presence of relevant medical facts, the medical basis, and the rationale for the medical opinion being expressed by the Medical Consultant. The memo should use language that is understandable to the Claim Owner. If the information on the memo does not answer the Claim Owner's questions, or the opinion is not convincing or well supported by facts and scientific evidence, it is possible the Claim Owner will require another opinion or an IME.

WCB audits the memos that Medical Consultants write for the Claim Owner. The audit checks that the memo meets the purpose for which the Claim Owner requested the opinion. The Medical Consultant's opinion should be based on medical evidence and must include an explanation of how the Medical Consultant came to his/her decision. The quality of the memo is important in determining how the opinion will weigh in the adjudication, and therefore it may impact the quality of the adjudication itself. The clarity of the Medical Consultant memo impacts the quality of the decision letter that the Claim Owner writes, since the letter must explain the medical opinions and the weighing of the opinions if they are different.

Particularly, when the Claim Owner has accepted the Medical Consultant's opinion over the Treating Physician's, the Claim Owner's ability to explain their rationale to the injured worker depends, in part, on the quality of the memo. The worker is more likely to be unsatisfied and dispute the decision if the reasons are not clear and understandable to them.

During our interviews, Appeals Advisors expressed that the explanation provided in the decision letter tends to be less helpful when the Claim Owner is accepting the Medical Consultant's opinion over the Treating Physician's opinion. Injured workers are less likely to accept the decision if it is based on the opinion of a physician who has not examined them. An early, collaborative approach involving the Treating Physician and the worker's representative could help alleviate and avoid the distrust that is often the cause of many disputes.

7.6.3 Quality Assurance and Service Standards

The Medical Consultants performance evaluation score is based on five separate factors of which the quality assurance audit of the memo weighs for 33% of the score. The quality assurance factor includes an audit of the writing quality and the turnaround time. The threshold for receiving the full incentive pay related to the quality assurance score is 80%. Data from the audits indicate that the average audit score was above 98% consistently over the last three years.

There are financial incentives in place for MCs for meeting turnaround targets. Incentive payments for timeliness are higher if the service is completed within seven calendar days, and the incentive pay drops by 70% when the service is completed within 8-14 calendar days. Additionally, Medical Consultants receive a performance bonus for achieving overall targets for turnaround time. For example, when 75% of a Medical Consultant's services are completed within seven calendar days of the referral, they are eligible for an additional 2.5% payment on their total billing.

Upon reviewing the incentive plan provided to us by WCB, we have concluded that it does not incentivise the use of quality enhancing processes such as CCOP and information sharing, which eventually reduce the chances of a dispute. An example of this is seen when the Medical Consultant's opinion differs from the Treating Physician's opinion. If the Medical Consultant sends any new information to the Treating Physician, they are required to allow at least seven days before completing their CCOP. If the Medical Consultant waits for the CCOP to take place, they will likely go past the turnaround standard, even when the turnaround days are adjusted, and lose the incentive pay. If CCOPs delay more than 25% of Medical Consultants opinions beyond the seven-day turnaround, they will also lose the collective performance-

based incentive. There is a need to balance the incentives for timeliness with the requirement for due process, and to align with the CCOP and information sharing standards that WCB has put in place.

Recommendation 17:

a) WCB update Medical Consultant memo audit tool to include factors that improve quality of process such as completion of contact with Treating Physician, and information sharing with Treating Physician.

b) WCB review the service standards and incentive plan for the Medical Consultant to improve balance in incentives for timeliness, quality of process, and quality of output.

The Medical Consultant opinion is an important component in the value chain of a good adjudication decision. Investing in the quality of the medical opinion and the memo from the MC to the CO will improve the quality of adjudication and the decision letter. Service standards for the Medical Consultant, as with any work that directly contributes to client outcomes, must favour quality of the output and quality of the process over turnaround targets.

The medical adjudication process is a value chain which starts with the Treating Physician, and includes the Medical Consultant's opinion, which may be affected by the Medical Consultant's process of reviewing the information, gathering additional information, and applying their knowledge. There is evidence that CCOP's improve the chances of consensus and therefore reduce the risk of dispute with the worker. A good product requires a good process, and therefore the process that was used to arrive at the output is equally important for assurance purposes. Putting process aspects in the quality assurance tools sends a clear message that, while timelines are important for service delivery, they do not have priority over quality of the process and output.

7.7 Independent Medical Examinations

Section 38(1) of the WCA allows the WCB to ask a worker to undergo a medical examination at a time and place determined by the Board. These medical examinations are conducted by an independent physician selected by the worker from a roster of qualified medical professionals.

The WCB does not have policies specific to IMEs, but there are guidelines for when an IME may be requested. An IME might be requested when:

- There is a need to weigh medical evidence.
- There is a difference of opinion between medical providers.
- There are concerns with the worker's treatment.

An IME is used to assess or determine a worker's:

- Fitness to work
- Work restrictions
- Diagnosis
- Appropriate medical treatment/investigation
- Complex medical issues
- Relationship between the injury and work duties

Only a Claim Owner may request an IME. However, based on merit, they may accept a worker's or employer's request for an IME. In some cases, private representatives have urged clients to seek their own IME-like medical exams. WCB maintains that these are not IME's but consults that are often done by physicians who do not have the complete information and are done as a means to refute existing medical or IMEs already on file. These are not recommended by the Treating Physician or the WCB and are nearly always unnecessary. WCB may reimburse a worker for these extra medical exams only if they meet certain conditions.

WCB does not capture data on the reasons for requesting an IME, but has indicated that the reasons are primarily related to weighing of evidence, difference of opinion, and treatment options. This further validates that the quality of the Medical Consultant opinion is an important factor in the Claim Owner's decision to request an IME. If those contributing factors are mitigated through improvements in the quality of the process (requiring CCOP and information sharing) and the quality of the memo, it may have an impact on the number of IMEs being requested.

To request an IME the Claim Owner completes the required referral which upon authorization by the Medical Manager, triggers the process for selecting the physician from the roster, which is a list of about 24 pre-qualified specialists in different fields of medicine. Once the worker has indicated their choice or one is selected for them, the exam is scheduled. The IME report is sent to the WCB after the examination has been completed.

Data from WCB indicates that 60% of workers choose the first available specialist to conduct the IME. Nearly 80% of the IMEs are completed within 42 days and about 86% of workers are satisfied or very satisfied with the service. In 2019 there were 1417 IMEs completed, which is about 10% higher than the previous year although total claims administered were almost the same during the years (Appendix 15). Although IMEs are helpful, a reduction in the volume of IMEs may be desirable and can be achieved by targeting the appropriate drivers of IME volume as previously explained.

IMEs in Other Jurisdictions

BC

WSBC does not conduct IMEs. In cases involving medical complexities, the worker may access a Medical Return to Work Plan, which involves an assessment by a WCB selected physician who advises on the worker's readiness to return to work and may suggest further tests and treatments. 1,200 workers accessed this service in 2019.

SK

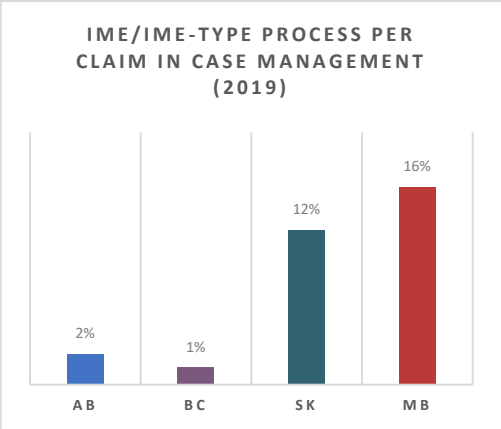
SWCB does not conduct IMEs. Instead, they have developed over 20 Multi-disciplinary Assessment and Rehab Teams throughout the province. Each team has a medical doctor, occupational therapist, physiotherapist, and/or chiropractor, and may also include a psychologist and/or orthopedic surgeon. The injured worker's physician or the Case Manager may request assessment by an MDA team. 1,000 assessments were completed in 2019.

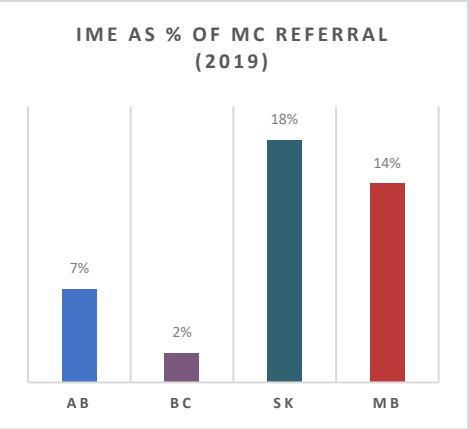
MB

There are IMEs in MBWCB, but they are infrequent. The number of IMEs and Medical Panels have decreased significantly since Medical Advisors began performing clinical exams and participating in early medical dispute resolution. Medical Advisors performed 2,000 exams in the past year.

ON

There are no IMEs in the WSIB system. They do utilize specialty clinics which may be asked to perform additional exams on the worker.





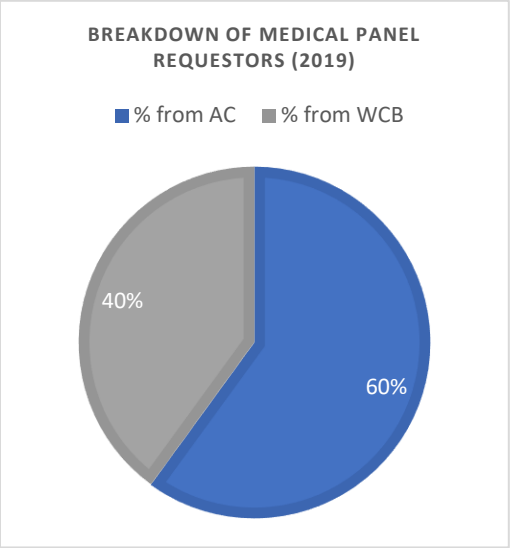
*Claim in case management calculated as open cases from previous year plus time loss claim in current year.

7.8 The Medical Panel

This section discusses the experience of the claimant if a medical adjudication cannot be completed based on the Treating Physician, Medical Consultant, or IME opinions. In this case the WCB or the AC requests a final and binding medical decision by the MP which has the statutory authority. A high-level process model for the Medical Panel is available in Appendix 12.

7.8.1 Request for Medical Panel

When conflicts of medical opinion cannot be resolved among the Claim Owner, Medical Consultant, and the Treating Physician, an opinion is requested through an IME. After receiving an IME report, if the Claim Owner decides there is an unresolved difference in medical opinion which is substantial and relevant to the claim, then a MP may be requested. WCA Section 46(3) allows a MP to be requested by the WCB, the AC, or by the worker.



If a MP has been requested, one can assume that a significant medical complexity or a difference in medical opinion related to a medical complexity exists. The fact that the opinions of three independent physicians - the Treating Physician, the Medical Consultant, and the IME physician are non-conclusive is also indicative of the level of complexity of the file.

The processing of the MP request can be quite long. A high-level model of the key steps and timeframes for the process is available in Appendix 13. The process begins with a Request for a MP which is sent by the WCB or the AC. A worker may request a MP only through the AC at the appeal stage of review. If the requester is the WCB, then it may have originated from the Claim Owner or the DRDRB, in which case it must be approved by the Manager of Medical Services at the WCB. Over half the requests for MP are initiated by the AC, of which some may have been at the request of the worker. Unlike the WCB, the AC may request a MP regardless of whether an IME has been performed.

The WCB prepares and sends the Medical Information Package (MIP) to the Medical Panel Commissioner. It takes an average of 31 days from the request for the MP to receiving the Medical Information Package. A summary of the Medical Information Package is also prepared by the WCB, which if not included with the MIP may take an additional 5-10 days. The number of days it takes the WCB Medical Manager to

submit the request for MP from the day they receive the request from the Claim Owner or DRDRB is unclear. Discussion with the Medical Manager is needed to confirm that the request meets criteria, and to assess if other options may be more suitable.

7.8.2 Medical Questions

The Request for MP includes a list of medical questions (issues) that the MP is requested to answer. For WCB requests, the WCB Manager of Medical Services reviews the medical file and approves the questions that are to be asked to the MP. If the requester is the AC, then the Appeals Commissioners frame the questions. These are then sent directly to the Medical Panels Commissioner, with a copy also sent to the WCB Medical Manager. The AC does not have any medical professionals who review the questions before they are sent to the Medical Panels Commissioner.

Concerns have been raised by the Medical Panels Commissioner, in office at the time of writing the report, regarding the clarity, balance, and sometimes the context of the questions, when compared to the information available in the Medical Information Package. This puts the MP, at times, in a difficult position of answering medical questions when the questions do not appear to be directly relevant to the medical history. This happens more often when the questions are framed without the involvement of medical professionals (e.g. when the WCB Medical Manager was able to review/reword the AC's questions before forwarding to the MP. This practice was discontinued in 2019). The MP's answers depend on how specific and clear the medical questions are. Ambiguous questions may not return direct answers, which then become subject to interpretation by the adjudicator.

A different kind of concern exists when the MP is requested by the Claim Owner or the DRDRB. In this case the questions are written by the Medical Manager, who is a WCB employee. In effect, the WCB is seeking dispute resolution, while being the one to frame the questions that are asked. Although only a perception, the approach does not reflect neutrality. Stakeholders such as the Worker's Advisors are aware of this process, and perceive a potential conflict, because the Medical Panels Commissioner does not have the authority to seek information on the implementation of the panel's decision.

Current regulation does not delineate a role for the Medical Panels Commissioner, or any third party, in framing the questions to the MP. There is no provision either for the Commissioner or the MP to request clarification regarding the questions being asked. Legal opinion obtained by the MPO on the matter has indicated that the Medical Panels Commissioner may have a legitimate need to participate in the identification or narrowing of the medical issues when doing so is necessary for performing their

mandated duty related to identifying the medical specialties and the panel members. However, allowing the Commissioner a role in framing the questions might deviate from their primarily administrative function. Alternatively, allowing the MP to ask for clarifying a question when they have a need, has merit. This may be a reasonable request from the perspective of improving the quality of the outcome if the answer from the MP were to be affected without the clarification.

Recommendation 18:

a) Allow the Appeal Commission to consult a medical professional when framing questions for a Medical Panel.

b) Allow the Medical Panel to clarify a medical question before the hearing.

The questions to the medical panel are important determinants of the quality of medical decisions which in turn support efficient adjudication. There needs to be appropriate checks and balances in place to ensure that the questions are the right ones, and that they use appropriate medical language. Having provisions to review the questions before submitting to the Medical Panel and/or at the request of the Panel will better reflect best practice compared to the current approach.

The issues referred to the MP are the most complex medical matters and are needed for adjudication decisions. It makes sense to provide professional support to the AC if a medical professional is not in the panel. Involvement of a medical professional in framing of the questions will improve the quality of the medical panel decision, and also the quality of adjudication by removing ambiguity and risk of misinterpretation, both in the questions, and in the medical panel's answers. A worker/employer will continue to have the right to dispute a claim decision if the adjudicator has not implemented the medical panel decision appropriately, or if the adjudicator's interpretation of the medical panel decision is different from the panel's intent.

A comparable provision exists in the Appeals Commission's procedures, where the Commissioners can modify the issues under appeal after they are submitted to the AC. The Commission may hold a pre-hearing meeting or can modify the issues before the hearing with the worker's consent.

7.8.3 Selecting the Medical Panel

The Medical Panels Regulation requires that the Medical Panels Commissioner create a list of eligible panel members and allow relevant parties to select their choice of one panelist from the eligibility list. The

work consists of identifying qualified doctors from the College of Physician's database and then contacting them through phone calls. The most time-consuming step within the Medical Panels Commissioner process is creating the eligibility list of qualified doctors and awaiting the choice of the panel member from the worker, employer, and the WCB. This step takes an average of 238 days, while the actual effort is only 15 hours. The duration of this process is extremely difficult for those who have to wait for the decision, compared to the real value addition.

While the option exists for the injured worker and employer to select a physician for the MP, more than half choose not to exercise this option. Injured workers are rarely able to appreciate the qualifications of the physicians in the context of their medical situation. Some have even consulted their family physician for advice in their selection, creating a hidden cost for the health care system.

Regulation allows the Commissioner to appoint a MP member on behalf of any party if they do not indicate their choice within a reasonable timeframe, and this approach is increasingly exercised. Based on our analysis, if the requirement for allowing a choice of MP members is removed, the effort needed to coordinate the Panel could be reduced by at least nine hours, and the process timeline cut by at least 64 days.

Recommendation 19: Streamline the Medical Panel selection process by removing the option given to the worker, employer, and the WCB for choosing a Medical Panel member. Allow the MPC to appoint the Medical Panel from the eligibility list.

Medical Panels represent a very small proportion of the disputes in the system. Having a choice in selecting the panel is desirable but not necessary. The utilization rate and the time it takes to complete the process do not align with the rationale for process efficiency and value. Due to the very small number of medical panels requested, it is not possible to determine if the worker or employer are making a better selection than if the panel was appointed by the Commissioner. It is also not possible to determine if the panel decisions in the current state are any better than if the panel was appointed by the Commissioner.

A Medical Panel is a specialized medical service, and therefore not subject to the *Canada Health Act*. Eliminating the option to choose the panel member does not infringe on the rights of the worker under the Act. There is no other dispute resolution mechanism within WCB Alberta that allows the disputing parties to appoint a decision maker.

7.8.4 Coordinating the Medical Panel Hearing

The physicians who are selected for the panel come from specialized fields of medicine, and therefore are busy professionals. Coordinating a MP hearing date is a logistical challenge and takes several weeks. Due to their busy calendars, the hearing date can be 3-4 months from the date that the panel is finalized. Much of the elapsed time is dormant time for the file, which could possibly be reduced with some innovative approaches. The duration could be reduced by using a combination of strategies, such as providing incentives to be available sooner, selecting the MP based on first available physician, and allowing the Medical Panels Commissioner to select alternative specialties to increase the options. The work in coordinating the hearing date can also be reduced by using technologies which enable collaborative scheduling instead of making separate phone calls, or if the hearing date is determined before selecting the panel members.

7.8.5 The Medical Panel Hearing

The Medical Panel Hearing usually takes 2-4 hours and is held in a facility which is equipped with a medical examination room. The attendees include the three MP members, the injured worker, their representatives, and other approved participants. The hearings are held according to the Medical Panel

Rules of Procedure and guidelines that are provided to the MP, ensuring that the principles of administrative justice, transparency, and respectful behaviour are followed.

The final report is written by the Chair and reviewed by the other panel members. It is submitted by the Chair to the Medical Panel Commissioner. The Chairs are not trained in medico-legal writing, but they are provided some guidelines for writing their decision report. Unlike the AC, the MP does not have a pool of pre-designated Chairs. The Medical Panel Chair is different for each hearing, and therefore the final reports are not of a consistent quality. The Medical Panel Commissioner does not have the authority to recommend any changes in the report but does ensure the Panel has answered the medical questions posed.

The Commissioner sends a copy of the report to the relevant parties. This process, from the MP hearing to completing the decision report, takes an average of 31 days. The whole process from requesting a MP to the decision report takes on average 411 days and costs about $20,152 per request (appendix 13). The final report from the MP is received by the requestor (WCB or the AC) and the directions are incorporated in the adjudication decisions that required the MP in the first place.

The Medical Panels Commissioner does not have authority to request a report on the implementation of the decision made by the MP, and is not accountable for the application of the decision by the WCB or the AC.

Recommendation 20: Make selection of Medical Panel members and hearing date easier and faster by using enabling technology.

The manual method of completing the panel selection and scheduling of the hearing date is time consuming and avoidable. Considering the medical complexities associated with these cases, it is even more imperative that administrative delays be minimized, and decisions be made in reasonable time.

It should be feasible for the Medical Panel to leverage technology to combine the panel selection and the date selection in a single step. This can considerably shorten the duration. Technologies exist to enable this process, for example Doodle Poll, and most other survey tools in the market allow polling capability.

Medical Panels in Other Jurisdictions

SK

Only the injured worker can request a Medical Review Panel (MRP) in Saskatchewan, and only after adjudication by the final level of appeal (Board Appeal Tribunal). The panel consists of two practitioners selected by the worker from a list maintained by the Healthcare Services department. SK approved 4 Medical Review Panels, out of 23 requests in 2019.

MB

Similar to Alberta, Medical Review Panels may be requested by any level of adjudication in Manitoba's WCB and Appeals systems. The panel consists of three physicians, one each chosen by the Minister responsible for the Act, the injured worker, and the employer. Since initiating a number of early medical dispute resolution mechanisms nearly two decades ago, MB has reduced its number of MRPs from 40 in 2002 to 0 in the last two years. The time to complete the single MRP in 2017 was 192 weeks.

ON

ON does not have Medical Panels or Medical Panel-like processes. Instead, during the final level of appeals, the Workplace Safety and Insurance Appeals Tribunal has access to its own Medical Liaison Office which provides additional medical information and coordinates requests for medical assistance from Vice-Chairs and Panels. Two types of medical professionals may assist, Medical Counsellors (provide recommendations on additional information required for complex claims. Do not interact with adjudicators or claimants) or Medical Assessors (provide medical opinion on the case. In rare cases, may also examine the worker).

BC

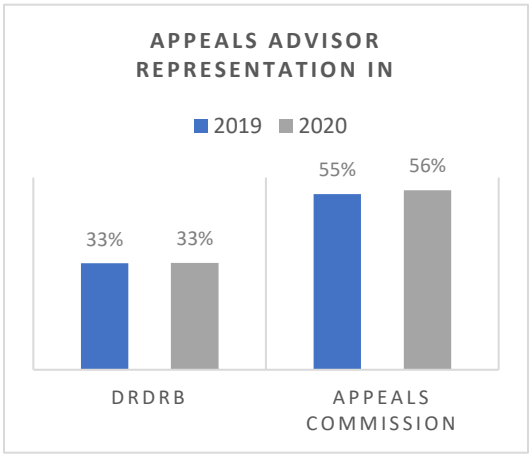
BC does not have Medical Panels or Medical Panel-like processes. If the Workers' Compensation Appeal Tribunal requires medical assistance or advice, they may select from a list of designated Independent Health Professionals (IHP) that is maintained by the Chair. The IHP only provides a professional opinion and does not adjudicate any medical dispute or difference of opinion.

8. The Appeal Advisor

8.1 Introduction

The Advisor Office (AO) provides the appeals advisor service through the Worker Advisor Branch which provides free appeals advisory services to injured workers, and the Employer Advisor Branch which provides similar services to employers.

Funded through the Accident Fund, the AO functions independently of the WCB and the AC although it exists as a branch of the latter. Appeals Advisors contribute to the WCB system by educating, assisting, and representing workers and employers throughout WCB dispute resolution and AC processes. The Appeals Advisors provide free advice and representation to workers and employers during all stages of a dispute. In 2019 the Appeals Advisors represented a total of 349 cases in the DRDRB, and 257 cases in the AC, representing 33% and 55% of the total worker and employer cases at those levels, respectively.



Depending on the stage of the dispute, Advisors act as an intermediary between the worker/employer and WCB, explaining the process and clarifying the decision the WCB has provided, as well as supporting a collaborative resolution. Worker Advisors can explain options, potential grounds for appeal, and commence the formal appeals process on behalf of the worker. By using informal dispute resolution methods focused on clarifying the decisions made by WCB they are able to assist the employer or worker in deciding whether they should proceed to the formal review and appeal levels. During the formal dispute resolution process, the Appeals Advisors help prepare submissions on behalf of the worker/employer and also represent them in hearings.

In addition to the Appeals Advisors, workers and employers may obtain services from other external sources such as services available through labour unions, and fee for service professionals such as lawyers, private appeal advocates, and corporate advisors. Workers and Employers also have the option of representing themselves in the appeal process.

8.2 Worker Advisors

8.2.1 Service Delivery Approach

Workers are able to engage Worker Advisors, free of charge, should they disagree with the decision made by the WCB. The conceptual process for an Advisor's role as a worker representative is shown in Appendix 14. The worker submits a request to the AO, upon which a pre-assignment review of the workers information is conducted. The AO has recently revised its evaluation for eligibility by making it more objective in order to increase access to the service. Once the request has been accepted, it is assigned to an Advisor.

Upon receipt of a worker's file, the Worker Advisor has five business days to initiate first contact with the worker. They will typically confirm the issues causing the dispute and inform the worker of the timelines, typically two to four weeks to review the file. Worker Advisors have real-time access to the worker's claim file through access to WCB's eCO system. Worker Advisors and the WCB Claim Owner communicate only through the eCO system. Appeals Advisors can add their own file notes in the system and make them invisible to the WCB. Worker Advisors can also submit Requests for Review and Resolution Memos through the system. All correspondence and actions are documented in the eCO system.

The Appeals Advisor Customer Service Standards exist to ensure they are providing quality and timely support. The initial process, from intake to the action plan should not take more than 20 business days. They must return phone calls within 24 hours, written correspondence within 48 hours, and provide monthly updates to the client by email, telephone, or in writing while the file is open. All communication must be clear, written in plain language, professional and written in a neutral tone. We were not able to confirm how well these service standards are being met by the AO, because this data is not being collected or reported, and has not been in the past.

8.2.2 Early Resolution

As decision letters can be fairly complex and include references to a number of policies and medical information, it is not surprising that injured workers may have difficulty understanding the letter. The worker can speak with the Claim Owner for clarification, but they may be unable to fully convey their difficulties in understanding the details of the decision, or they may not trust the Claim Owner's explanation. One of the first objectives of Worker Advisors is to fully understand why the worker objects to the decision, as well as to explain how the WCB decision was made. Claim Owners have stated that even though the worker may be hearing the same information as was in the letter, or that was explained

to them by the Claim Owner, workers find it helpful to hear it from a neutral third party, like the Worker Advisor. Worker Advisors are able to resolve about of 20% of those cases they take, through initial conversations prior to any escalation.

The Worker Advisor role supports early resolution by helping to convey the worker's perspective to the Claim Owner and mitigating any misunderstandings. They submit a Resolution Memo through eCO system which presents information from the worker to the Claim Owner regarding their issues and their interests. While the Worker Advisors do communicate on behalf of the worker, they also help maintain the relationship between the WCB and the worker. Claim Owners commented that some workers may be emotionally fragile, depending upon the nature of their injury or health condition, and having the support of the Worker Advisor is beneficial for them.

For disputes that advance to the DRDRB, it may take multiple conversations between the Resolution Specialist and injured worker before the issues are fully understood. Resolution Specialists have cited that the clarification of the worker's perspective by the Worker Advisor often makes the process easier for all parties. Claim Owners and Resolution Specialists have experienced that with certain types of medical conditions such as psychological or mental health, facilitating an understanding with the worker of the impending decision and even gathering the necessary information from them is challenging. Having access to a neutral/third-party intermediary (without needing legal representative status) earlier in the process to explain the decision and the fairness of it or otherwise, could reduce the chances of a dispute later on. Some stakeholders in WCB who we interviewed suggested broadening the Worker Advisor role so they could be involved, under specific circumstances, even before a decision is made.

8.2.3 Knowledge of the System

Claim Owners and Resolution Specialists state that by involving the Worker Advisors, workers are gaining access to qualified, knowledgeable, and empathetic advocates. The Advisors knowledge includes both policies and procedures. They have the ability to break down the reasoning behind a decision so that the worker can understand the policies that form the basis of the decision. Most of the Appeals Advisors have experience working in WCB, have extensive experience with the WCB dispute resolution process, and can guide the worker through the process from mediation with the Claim Owner, to an appeal at the AC. Worker organizations also commented about the expertise that the Worker Advisors bring to the dispute resolution process on behalf of the worker.

8.2.4 Motivation

Worker Advisors are government employees and they do not have any financial interest in the injured worker's dispute. The stakeholders feel that the worker advisors advocate for the interests of the worker professionally and rationally. Additionally, Worker Advisors take a holistic approach to the injured worker's interest, which includes ongoing medical treatment and overall well-being, in addition to financial entitlements.

8.2.5 Education and Training

Worker Advisors are required to have a degree or diploma with courses in arbitration, legal, business, or insurance. They must have advanced technical knowledge of the WCA and associated legislation, regulations, policies, and procedures. All Worker Advisors must also complete the Certificate program in Tribunal Administrative Justice (CTAJ). CTAJ courses, offered though the Foundation of Administrative Justice, prepares the Appeal Advisors with knowledge and skills related to principles of administrative justice, decision making, investigation, tribunals, and cultural competencies.

Worker Advisors must abide by the WCB Code of Rights and Conduct as well as the AC's Standards of Behaviour for Representatives and Participants. These ensure all Worker Advisors are treating clients with respect and dignity, maintaining clear lines of communication, and are well prepared for and knowledgeable of the appeals process.

8.2.6 Challenges Faced by Worker Advisors

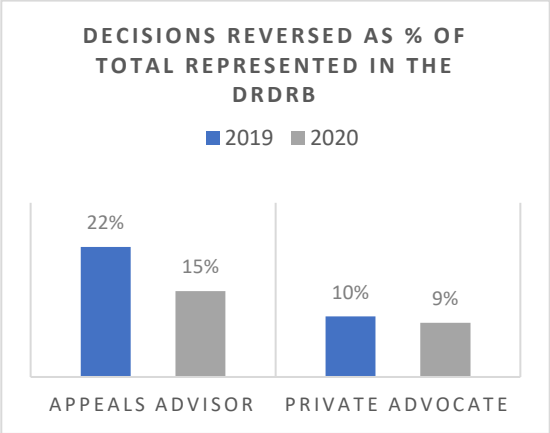
In our consultations with the Worker Advisors, we heard about the following operational challenges faced by them:

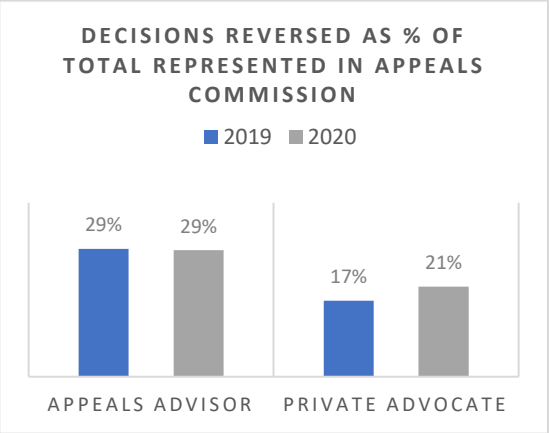
- Worker Advisors currently have approximately 40 files assigned to them, while a review done by Engage First Management Consultants in 2019 indicated the ideal caseload to be in the low 30s.
- The AO has an approved budget of 21 Worker Advisors and 3 Employer Advisors, in addition to managers and administrative support staff. The Advisor team was short of staff by over 33% for the past two years, making it difficult to meet their customer service standards. Vacancy rates have recently decreased to about 15% in the Worker and Employer Advisor roles.
- Claims have become increasingly complex, further stretching the capacity of the team to maintain a high level of customer service.

- Administrative tasks such as data entry, updating appeals status, and sending file access notes take up a substantial amount of the Worker Advisors time.
- There is concern that with the recent reorganization of the Advisor Office its independence will be difficult to maintain, in some stakeholder's perceptions, without continuous and proactive stakeholder management and communications.

8.2.7 Outcomes

The charts below show that the results obtained by the Appeals Advisors are better than those of private advocates. This is true of the outcomes both at the DRDRB and the AC. In 2019, the Appeals Advisors represented 589 issues in the DRDRB compared to 558 by the private Advocates. Similarly, in 2019 the Appeals Advisors represented 436 issues in the AC compared to 326 represented by the Advocates. Their relative success in reversing the original decision is compared in the charts below. As Appeals Advisors are a free service, the net financial proceeds of any benefit adjustment to the worker would be more when they have an Appeal Advisor, compared to when they hire a fee for service advocate.





8.3 Employer Advisors

8.3.1 Role

The Employer Appeals Advisors are a relatively new service, having been created in 2017. It is a service provided by the Advisor Office in the AC. Employer Advisors provide support, advice, representation, and education to employers who have a disagreement with a decision made by the WCB.

It should be noted that the EAB is separate and independent from WCB's Employer Appeals Consulting service (EAC). The latter is a service of the WCB which is similar to the EAB, except it does not provide

advocacy and representation for the employer, and it does not prepare any written submissions for appeal on behalf of the employer. Based on the description of the two services, there is an obvious overlap of function between the EAC and the EAB. The EAB services are more comprehensive than the EAC, and they are external and independent of the WCB. There may be an opportunity to differentiate the EAC services so that employers can receive different value-added services that are not available from the EAB.

In Alberta small businesses employ approximately 74% of the workforce and makeup the biggest proportion of WCB clients. Employers, especially those who do not have the resources to understand and navigate WCB's complex claims processes, can benefit from this service. Employer Advisors help employers to clarify and navigate the complex WCB process using their advanced knowledge of the system. Their case management practices, processes, and service standards are similar to those of the Worker Advisors.

Employer Advisors' employment conditions, job expectations, and required qualifications are exactly the same as those of the Worker Advisor. Likewise, they must abide by the Appeals Advisor Customer Service Standards, the WCB Code of Rights and Conduct as well as the AC's Standards of Behaviour for Representatives and Participants.

The Worker and Employer Advisors are organized in separate business units and work independently of each other in order to avoid any conflict, i.e., if they were representing opposite sides in the same dispute.

8.3.2 Challenges Faced by Employer Advisors

We were informed by the EAB of the following challenges in their operations:

- Despite being available for three years, there is low awareness among stakeholders of the Employer Advisor service. Based on a survey, approximately 75% of employers are not aware of the service.
- Employer Advisors do not have direct access to the worker's claim record on eCO System. They are also restricted from seeing the worker's personal information that the WCB may deem not relevant to the dispute. This may present challenges in fairly representing the employer when the restriction on the content is not objectively decided in relation to the needs of the Employer Advisor.
- When an Employer Advisor requests access to a worker's claim information, there is a minimum 15 day waiting period, which can create delays to the resolution process.

Note: The main challenges related to independence of the AO and access to information were addressed through recommendations in an earlier section of this report.

Recommendation 21:

a) Continue the Employer Appeals Advisor service and rationalize services between the Employer Advisors Branch (EAB) and the Employer Appeals Consulting (EAC) service to reduce duplication.

b) Improve awareness among stakeholders of the availability of the Appeals Advisor service through better communication and promotion.

There is a significant overlap of services between the EAB and the EAC. The EAB is relatively new but has a broader scope of service than the EAC, and it is external and independent from WCB. The EAC only provides consulting and advise without representation, and it is internal to WCB. Combining the two teams will enable the service to handle increased demand when information and awareness increases. During our consultation, employer groups did express the desire for the EAB service to be more accessible. The recommended change will help meet that expectation, and also balance out the system funded appeals advisor service for workers and employers in terms of size and scale. Combining the teams will also allow benefits from economy of scale, and increased capacity. An alternative would be for WCB to repurpose the EAC to avoid redundancy by providing a different set of value-adding service.

Approximately 33% of the DRDRB reviews are represented by Appeals Advisors, and only 25% of employers are aware of the free employer appeals advisor service. This is a clear indicator of low awareness among the workers and employers at the early stages of the dispute and indicates that there is room for growth in the utilization of this service, subject to available capacity and ability to expand service.

Ideally, every worker and employer could be pre-emptively informed and made aware of the appeals advisor services so that they can make a conscious choice with full information. The utilization of the appeals advisor service can be increased with more awareness and information. Utilizing the services of an Appeals Advisor is a choice that a worker and employer makes. They will continue to have the option to choose a private advocate or self representation if they prefer.

Targeting growth in the utilization of the AO services could potentially yield better results for the whole system. Clients will benefit from early resolution and more favourable outcomes as their past results have shown, and the system will benefit from saved costs.

Appeals Advisors in Other Jurisdictions

Advisor Office

All jurisdictions have Advisor Offices that are administered by a provincial ministry and work independently from WCB, and appeal-related bodies. Alberta is the only province whose Appeal Advisors are not organizationally situated in a government department.

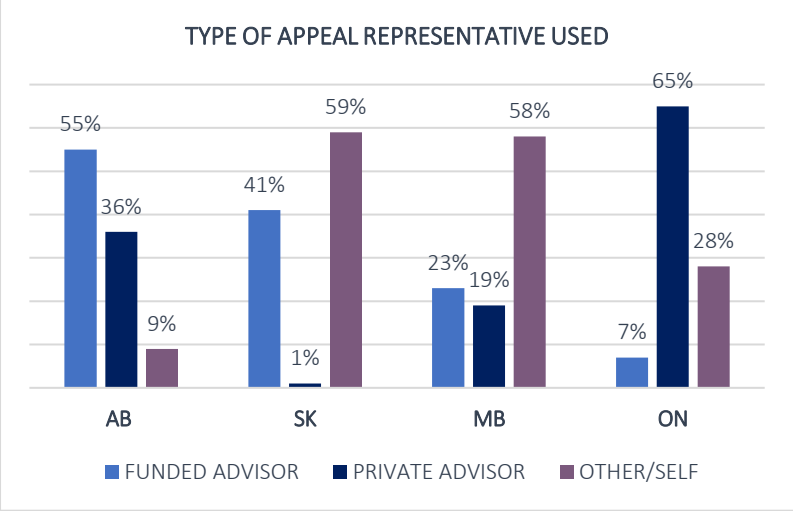
Worker Advisors

All jurisdictions included in this report have Worker Advisors that provide advice and representation to workers appealing a WCB decision.

Employer Advisors

Ontario and British Columbia's Employer Advisors provide similar services to Alberta's Employer Advisors, including advising, representation, and education. Saskatchewan does not have Employer Advisors who represent the employer in appeals, instead they have an Employer Resource Centre that provides education and advice on the WCB system. Manitoba does not have Employer Advisors or resources.

The chart below shows that the utilization of funded appeals advisors is higher in Alberta than in the rest of the provinces in the final appeal.



8.4 Other Forms of Advocacy and Representation

8.4.1 Self-Representation

WCA does not place any restriction on who may represent the interests of a disputing party as long as the party agrees to appoint the person as a legal representative. Some workers and employers may choose to represent themselves throughout the decision review and appeals process. The AC recommends that having professional representation is helpful for workers and employers in the hearing because of the knowledge and skills required. We do not know the exact reasons why someone would choose to self-represent when there are professional advisors available through the AO without any cost to them. At least some of those who self-represent likely did not qualify the pre-assignment review (or the merit review when it was in place before April 2021) that the AO or some private advocates conduct. Others may have decided to self-represent because they have knowledge and prior experience in representing themselves in formal disputes, and others because they do not have the financial means to pay for a private advocate. Navigating through the dispute resolution process requires knowledge of the system and skills in negotiation and advocacy, in addition to the time commitment. Self-represented parties are still responsible for completing and submitting all required documents within the allotted timelines and abiding by all standards and codes of conduct for representatives throughout the dispute resolution process. Both the DRDRB and the AC assist the self-represented worker/employer in their own processes but they do not advise the worker/employer on their course of action.

About 38% of reviews are self-represented in the DRDRB but less than 10% of all appeals are self-represented in the AC. Self-represented workers and employers were able to reverse or vary 35% of the decisions in the AC. This result is comparable to the results obtained by the paid advocates but less than the 45% achieved by the system funded Appeals Advisors.

8.4.2 Non-Profit Agencies

There are various non-profit organizations whose mandate is to provide free advocacy and support to workers filing a dispute related to a WCB claim. For example, in Alberta the Worker's Resource Centre's mandate is to provide free assistance to Alberta workers. Their Casework program assists with system navigation and represents workers filing a WCB claim and/or going through the WCB appeals process.

Workers may also get assistance from the Canadian Association of Workers' Advisors and Advocates (CAWAA). CAWAA provides free, confidential, independent advice on WCB claims, regardless of the jurisdiction in which the claim lies. They can assist with system navigation, decision clarification, as well as

preparing and presenting claims to the relevant appeal body. They have offices located throughout Canada.

Other free services such as the Edmonton Community Legal Centre and Calgary Legal Guidance offer free advice through their "Dial-A-Law" programs, which provide general information on legal issues including worker compensation.

8.4.3 Union Appeal Advisors

Some unions provide an advisor to assist a member with WCB claims and dispute processes. This service is typically provided as a benefit to a union member. For example, the United Food and Commercial Workers (UFCW) Local 401 has a WCB Advocacy Department that supports members throughout the WCB process. Similarly, United Nurses of Alberta provides support for nurses who are injured at work and have a WCB claim or a dispute related to their claim.

8.4.4 Private Advocates

Workers and employers can engage a private advocate to assist them with the claims process. This may be a fee-based service from a lawyer, paralegal, an independent consultant, or a free service from a trusted friend or family member. Any fee associated with the hiring of a private advocate is the responsibility of the worker or employer. Private advocates, just like Appeals Advisors, must receive written permission to act as a legal representative for a worker or employer. Private advocates may have some prior WCB experience or knowledge, however there is no requirement to have any certification in dispute resolution or mediation or any WCB training.

Alberta does not have a very large pool of private advocates, estimates range from 20-50, but there are many law firms that practice in the field of workers' compensation. Some of the private advocates currently practicing in Alberta have been employed by the WCB in adjudication or claims management at some point in their career. The private advocates do not have a professional association or a regulating body, although some of them may be members of the Foundation for Administrative Justice (FOAJ) which represents professionals in mediation and administrative justice.

8.4.5 Fee Structure

Private advocates charge a fee for their service. The fee structure varies, with most charging a base fee for initial consultation, a fee for file review, and a commission or fixed fees for representation and resolution. In the case of worker representatives, the payment is usually a percentage of any additional benefit or

entitlement they are successful in getting from the appeal. The percentage varies but is generally between 20%-30% of the funds awarded. The commission structure also varies based on whether the worker receives adjustment for past payments, or if future benefits are increasing, or both. Some advocates also offer a per diem fees or hourly rate if the client prefers. Some advocates may take an upfront fee to review the client's case, regardless of whether or not they decide to take the case.

8.4.6 Regulation

In Alberta, there are no restrictions on who can represent an employer or a worker, and there is no body that regulates the profession. The Alberta Appeal's Commission's Practice Guideline #3B: Standards of Behavior for Representatives and Participants outlines expectations and standards of conduct for appeal participants and representatives involved in the appeal process. Expectations for representatives are:

- Act honestly.
- Obtain proper instructions.
- Act properly and in a timely way.
- Know the Appeal Rules.
- Guide the client on appropriate conduct; and
- Be aware of the rules of conduct and adhere to them at all times.

As long as the representative abides by these guidelines, and a Notice of Representative form has been accepted by AC, any individual deemed appropriate by the claimant may act as a legal representative. The same rules apply to all types of representatives including Appeals Advisors.

8.4.7 Challenges Related to External Advocate Services

There are varying opinions among stakeholders about the role of the external advocates who assist workers and employers in the workers' compensation dispute resolution process. Some of the opinions may be subjective and based on a specific experience, these observations should not be generalized as reflecting on all external advocates.

A common concern among the stakeholders we consulted with, stems from the fact that worker's have to pay for the private advocate when they are facing perhaps the most difficult time in their life, both financially and in health. Most stakeholders do not think this is a desirable situation but understand that some workers will probably voluntarily choose to pay for the service. However, stakeholders do think that it is for the system agencies to raise awareness about the availability of the free advisory service. In one

instance during our consultation, a private advocate indicated that Claim Owners do inform the workers about the availability of private advocates as an alternative.

Some WCB staff also shared challenges when dealing with the private advocates. It has been noted that once a worker hires a private advocate, the advocate typically controls the relationship between the worker and the WCB. As a result, the worker can become isolated from the process and dependent on the advocates narrative. It is also possible that the worker is influenced by the advocate's own disposition towards the WCB. This may affect the likelihood of an early resolution. Most private advocates will only communicate in writing, which not only makes it less efficient, but also inhibits collaboration in resolving the dispute. It has also been experienced that some advocates withhold information from the Claim Owner and DRDRB until the case reaches the AC. The WCB staff that were interviewed think that this stems from the advocate's belief that the entitlement would be higher if decided by the AC.

Some WCB staff also indicate that there is significant disparity in the professionalism and knowledge of the WCB process among the private advocates. The workers do not realize that the advocates may not have any form of professional affiliation, like lawyers do, and many do not have dispute resolution or mediation training. Their understanding of policy and legislative changes may not be up to date. As a result, the quality of the communications from private advocates also varies and can take the Claim Owner or Resolution Specialist time to understand what is being conveyed.

WCB allows workers and employers to send requests in a letter format provided it has all the necessary information as required in the application form. Due to this reason, some Claim Owners and Resolution Specialists notice a significant variance in the content and quality of the Request for Reviews and Resolution Memos done by the private advocates. In one example, a private advocate listed 64 issues to be reviewed by the DRDRB. In the DRDRB's opinion, most of the issues were redundant or did not relate to a decision about compensation or benefits, nevertheless the request resulted in a 73-page Decision Memorandum from the DRDRB.

Stakeholders say that some of the private advocates are ex-employees of the WCB who may have left their jobs on unfriendly terms, and this may reflect in their attitude during negotiations with the WCB. We reviewed the websites of a few private workers' advocates. We found that their marketing quite often mentions unsubstantiated accusations about the government offered Appeals Advisors and about WCB's adjudication. This may reflect the beliefs or perceptions of these particular advocates.

Private Advocates in Other Jurisdictions

British Columbia, Saskatchewan, and Manitoba

Similar to Alberta, all three jurisdictions have expectations and standards guiding the conduct of representatives. However, there are no regulatory bodies or legislation governing the practices of private advocates.

Ontario

Ontario is the only jurisdiction that has clear policies regulating private representatives working on worker compensation claims and disputes. After the Law Society of Ontario received repeated complaints of workers and employers being poorly represented by individuals without the appropriate training, they stepped in to help regulate the service. To facilitate the transition, they allowed currently practicing advocates to take the paralegal exam.

Following the Law Society of Ontario's intervention, the WSIB updated their Operational Policy Manual, which defines who can be considered an authorized representative. An authorized representative is any person, firm, or organization that has the written permission of the worker or employer and has been licensed under the *Law Society Act*or is exempt from these licensing requirements. For example, lawyers, paralegals, union representatives, Aboriginal Court Workers, and representatives from the Office of the Worker or Employer Adviser.

WSIB also has a code of conduct for representatives that provides standards of conduct, as well as consequences for non-compliance. Penalties range from a verbal warning, up to and including investigation and prosecution by WSIB and/or police. Consequences for malpractice can include suspension.

The code of behaviour details the expectations WSIB has for all parties involved in the WSIB process. The code also outlines the penalties, including written warnings, contact restrictions, and contacting police for individuals who engage in the following behaviours:

- Abusive behavior.
- Threatening behavior.
- Criminal harassment and violence.

9. Implementation and Change Management

We conducted a systematic review of the processes and structures in the medical review and appeals processes of the Alberta WCS. Our review has identified some areas of improvement and addressed them through twenty-two recommendations.

The recommendations, when implemented, will have a significant impact on this critical part of the workers' compensation process, which has been a subject of criticism from some stakeholder groups in the past. Some of our recommendations will drive fundamental changes in the quality of adjudication decisions and in the review of decisions by the WCB. The implementation of our recommendations may require changes in legislation, policy, or operations. The benefits expected from these recommendations would be financial e.g., cost savings from avoidance and process improvement (i.e., streamlining and shortening of processes); or in qualitatively improving the experience of the injured worker and employer. Fundamentally, all the recommendations are aimed at preserving and enhancing the system's reputation of offering a fair and effective dispute resolution process. When implemented, the recommendations will make Alberta's medical review and appeals processes more efficient, better aligned, and more supportive of client outcomes.

Several recommended changes are focused on an avoidance of escalation in disputes while other recommended changes will increase the access to professional supports for workers and employers who need them. The latter may increase the volume of referrals for dispute resolution, however, on the whole it makes the system healthier and more aligned with the foundational principles of workers' compensation. Therefore, even though the impact of some recommendations may appear to counteract the impact of another, it should not diminish the need for both types of recommendations to be implemented.

9.1 Benefits and Value

The recommendations, when implemented, will improve the future experience of the system stakeholders including those who deliver these services. We list the expected impacts on each stakeholder group later in this section.

Our analysis indicates that the cumulative impact of the recommendations may achieve a 20-30% reduction in referrals to the DRDRB, and reductions in appeals, Medical Consultant and IME referrals of about 15-20% each.

In addition, the report identifies opportunities for reducing the process durations in DRDRB, AC and MP by about 60-100 days mainly by better managing postponements and process inefficiencies. Financial analysis indicates that when implemented, the recommendations could deliver savings of approximately $3.0 million per year. About 55% of the savings is expected to be realized from process improvement and reduction in the number of appeals, and the remaining 45% from reduction in the number of medical consultations and CSD/DRDRB reviews in the WCB. The savings do not include the intangible benefits that would be realized from qualitative improvements in the processes and in the experience of the stakeholders.

There will be some investments required in order to realize the projected benefits, for example, additional resources may be required in the Advisors Office and in the WCB to handle increased volume from increased awareness of the services. We estimate that when implemented, these recommendations could deliver quantifiable net savings (after costs) of about $10 million in present value terms over the next five years. These do not include the intangible benefits that would be realized from qualitative improvements in the processes and in the experience of the stakeholders, or the economic benefits from faster return to work.

9.2 Next Steps

The critical success factor for realizing the benefits depends on successfully aligning and improving the upstream processes i.e., adjudication decision and communication, medical consultant referrals, and DRDRB decision review. Implementing the recommended changes will require executive intent and willingness to make the changes.

Commitment from the leadership of the WCB and the AC will be critical for the success of this review. Further work may be required to expand on and understand the broader implication of each recommendation and to determine the work needed to get to the future state.

The immediate next steps should involve developing a shared understanding of the recommendations among the broader stakeholder group in the system and getting support from the system agencies who are most impacted. Following the consultations, a more detailed response to the report with an implementation plan should be requested from the system agencies. We recommend the following steps be taken to ensure that the recommendations are effective in their purpose:

- Allow key stakeholders an opportunity to provide input on the report. This will improve adoption of the recommendations.
- Assign leadership and accountability for implementing each recommendation.
- Maintain momentum with sustained sponsorship and a commitment to a timebound execution.
- Include staff who are affected by the change as part of the solutioning and implementation effort.
- Identify and mitigate risks early in the process.
- Use a systemic approach to the implementation process since there are interdependencies.
- Develop a monitoring and reporting framework for the implementation.
- Develop a communication strategy to keep stakeholders informed.

The overall timeframe for implementing these recommendations should be approximately two years as shown in the high-level roadmap at the end of this chapter. Further work would be required to determine a detailed implementation plan considering real-life constraints, capacity, and inter-dependencies. The section below outlines the impact that various system stakeholders will experience when the recommendations are implemented. When these changes are being planned, an effective change management and communication strategy should be activated to raise awareness among workers, employers, staff, and other key stakeholders. The communication should emphasize the reasons these changes are needed and what improvements the stakeholders will see. The community physicians should also be targeted in the communications so that they understand how their professional opinions will be gathered and valued in future transactions. An effective change and communications strategy will be essential for maximizing benefits realized from the changes in the medical review and appeal process.

The implementation of these recommendations should be grounded in the principle that the quality of experience during dispute resolution measured in fairness, transparency, and timeliness, can be improved. While operational and policy improvements will bring about the initial change, long-term success will depend on sustaining the recommended changes in the system.

Alberta's WCS is among the better performing workers' compensation systems in Canada based on the metrics that are reported by all provincial systems. With the recommended changes Alberta will clearly demonstrate its commitment to improving the experience of those workers and employers who are not satisfied with WCB's decisions, and providing them a fair chance to amends as needed.

9.3 Expected Impact on Stakeholders

The recommendations of this review will have profound impacts on various stakeholders both in the short-term and in the long-term. Some of the key impacts are listed below.

9.3.1 Impact on CSD

a. Claim Owner will be able to talk to the Treating Physician, with the help of the Clinical Consultant, without needing to refer to the Medical Consultant when only additional information or clarification is required from the Treating Physician.
b. Quality of adjudication should improve with more objective weighing of medical evidence based on higher rates of consensus between Medical Consultants and Treating Physicians.
c. Decision letters should be better in communicating the decision and the rationale with new and more robust quality management measures and a continuous improvement approach. There may be fewer enquiries because errors or lack of clarity can be proactively corrected before decision letters are sent out.
d. Streamlining of support in the early stages of the dispute process should help ensure workers and employers feel supported in the resolution of their disagreement leading to more positive interactions with Claim Owners.
e. Claim Owners should be able to resolve more disputes in the early stages through more collaborative interactions with the worker/employer and their legal representative.
f. There should be fewer disagreements and disputes, allowing CSD to focus on their core responsibilities of claim adjudication and management.

9.3.2 Impact on Medical Consultants

a. Medical consultants would be involved only when a real disagreement on medical opinion exists that cannot be resolved between the Claim Owner and the Treating Physician. They will not be an intermediary for seeking clarification or additional information from the Treating Physician.
b. There should be a reduction in the volume of referrals to the MC driven by the above change.
c. The quality assurance of their memo would ensure that due process including information sharing and CCOP with the Treating Physician is part of the audit.
d. CCOP with the Treating Physician would become mandatory when there is a difference in medical opinion. This should increase the rate of consensus in medical opinions, potentially decreasing IME referrals as well as referrals to DRDRB and AC.

9.3.3 Impact on DRDRB

a. DRRB will become an independent decision-making body within WCB.
b. Resolution Specialists will have clarity in their role as independent decision makers.
c. The decision review process should be more efficient and streamlined with proactive management of reasons for postponement, improved clarity in the purpose of the hearing, and keeping forward momentum towards resolution.
d. Decisions made by the DRDRB should have more acceptance based on demonstrated fairness and transparency of process, potentially resulting in fewer appeals.
e. Relationship with workers, employers, and legal representatives should improve qualitatively.
f. With anticipated higher success rates through alternative dispute resolution in the early stage, there are likely to be fewer requests for review by the DRDRB.

9.3.4 Impact on Appeals Commission

a. The appeal process should be more efficient with proactive management of reasons of postponement and scheduling of appeals on a shorter timeline.
b. Average duration and cost of appeal to the system should decrease if AC can strategically utilize smaller panels and more documents-only hearing for initial appeals.
c. Medical Panel process would be streamlined and shortened by eliminating non-value adding steps in the process.
d. Appeals Advisors may experience an increase in demand for their service with increased awareness among workers and employers, potentially resulting in more early resolutions and fewer cases escalating to DRDRB and the AC.
e. Appeals Commission may see a decrease in the number of appeals however, the complexity of the issues may increase.

9.3.5 Impact on Worker/Employer

a. Workers and employers should have more information about, and access to, advice and guidance in the early stage of their disagreement with a WCB decision.
b. They would continue to receive services free of cost from a team of qualified professionals (AO) while still having the option to choose private or fee-for-service providers.
c. With anticipated improvements in the quality of adjudication and decision letters, there should be fewer disagreements and misunderstandings in the future.

d. In the long-term they may enjoy a more trusting relationship with the system, with increased assurance that processes are fair and transparent. Overall, they may see a qualitative improvement in their experience and more timely dispute resolution process, leading to less stress, anxiety, and possibly an earlier return to work.

9.3.6 Impact on the Workers' Compensation System

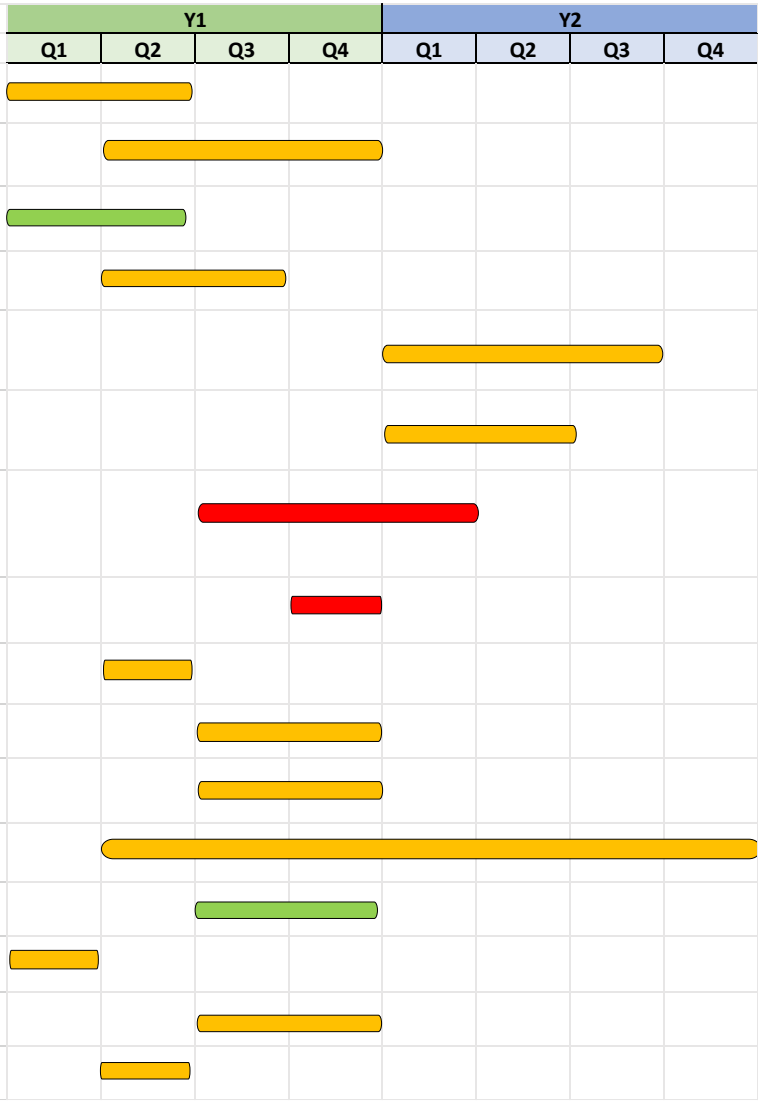
a. Alberta Workers' Compensation System is one of the better performing systems in Canada. With the recommended changes it will continue to show leadership in how it treats injured workers and employers who are not satisfied with a decision made by the WCB.

b. The system's proposed adopting of a uniform and integrated approach to information management, information sharing, quality assurance and performance management in relation to medical reviews and appeals processes, should improve system operations and client outcomes.

c. The system should experience a qualitative improvement in its relationship with injured workers and employers who are not satisfied with the decisions made by the WCB or the AC.

Proposed Implementation Roadmap

#	Recommendation	Lead
1	Clearly define the nature of the statutory decision review including the authority and accountability of the Review Body referred to in WCA section 9.3/9.4.	WCB
2	Require an independent review of the medical file when a medical dispute remains unresolved and determine an appropriate timing of this review.	WCB
3	Continue risk assessment and strategies to mitigate potential challenges emerging from the reorganization of the Appeals Advisors with the Appeals Commission.	AC
4	Facilitate sharing of relevant worker data, under appropriate assurances, which the Employer Appeal Advisors are entitled to for conducting their statutory responsibilities.	WCB
5	a) Create an information strategy that supports alignment in data definition and data capture for better performance management of medical and appeals processes across system agencies.	WCB
	b) Create reporting standards with common indicators and measurements for reporting the operational performance of decision review and appeals seamlessly among system agencies.	WCB
6	a) Strengthen the quality control and quality assurance practices for all key determinants of process outcome such as: MC memo, adjudication decision letter, DRDRB hearing and decision making, AC information package and hearing, MP hearing, and AA initial review and representation.	WCB, AC
	b) The Workers' Compensation System report annually on analysis of trends for disputed decisions and the quality assurance of decision-making processes from adjudication to	WCB, AC
7	a) Revise the decision letter template to include information about supports available for workers and employers seeking clarification or dispute resolution.	WCB
	b) Enhance the quality control of decision letters before they are sent out.	WCB
	c) Enhance the assurance audit of decision letters to include factors that improve the communication value of the letter, in alignment with the decision letter style guide.	WCB
	d) Adopt a continuous improvement approach to decision writing skills with feedback and re-training.	WCB
8	Redefine the role of the system funded Appeals Advisor to extend their advisory role in the early stages of dispute i.e. disagreement with the decision letter.	AC
9	Structure the 30-day duration for CSD resolution and implementation to be utilized in value adding collaborative actions.	WCB
10	a) Address the issues that cause high rates of postponement in the DRDRB, and target to eliminate postponement occurring due to avoidable reasons.	WCB
	b) Report the actual days for completion of reviews to reflect the real-life experience of workers and employers, and manage performance based on that metric.	WCB



#	Recommendation	Lead	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4
11	a) Define a clear governance and organizational model for the DRDRB to create an independent and arms-length operation from CSD. Delink the DRDRB role from any quality assurance or learning outcomes for CSD.	WCB								
	b) Redefine the decision-making model of the DRDRB to better align with expectations of a statutory decision review.	WCB								
12	Clarify the interpretation and application of policies where there are frequent differences between the Claim Owner, DRDRB, and AC decisions based on analysis of trends.	WCB								
13	Review the practice of DRDRB sending back a case for re-adjudication when new evidence is related to a decision in dispute.	WCB								
14	a) AC take appropriate steps to reduce the time between intake and hearing date, and between hearing and decision date for appeals that have fewer or less complex issues to within service standards.	AC								
	b) AC address the issues that cause high rates of postponement. Target to eliminate postponement occurring due to avoidable reasons.	AC								
	c) AC report the average duration for each type of appeal so the duration reflects the real experience of appellants.	AC								
15	WCB facilitate one to one follow up between the Treating Physician and the Claim Owner, with the support of a medical professional, when only a clarification or additional information on a medical opinion is needed.	WCB								
16	WCB require a mandatory contact between the Treating Physician and the Medical Consultant when the Medical Consultant is providing a medical opinion that is different from	WCB								
17	a) WCB update Medical Consultant memo audit tool to include factors that improve quality of process such as completion of contact with the Treating Physician, and information sharing with Treating Physician.	WCB								
	b) WCB review the service standards and incentive plan for the Medical Consultant to improve balance in incentives for timeliness, quality of process, and quality of output.	WCB								
18	a) Allow the Appeal Commission to consult a medical professional when framing questions for a Medical Panel.	AC								
	b) Allow the Medical Panel to clarify a medical question before the hearing.	AC								
19	Streamline the Medical Panel selection process by removing the option given to the worker, employer and the WCB for choosing a Medical Panel member. Allow the MPC to appoint the Medical Panel from the eligibility list.	L&I								
20	Make selection of Medical Panel members and hearing date easier and faster by using enabling technology .	AC								
21	a) Continue the Employer Appeals Advisor service and rationalize services between the Employer Advisors Branch (EAB) and the Employer Appeals Consulting (EAC) service to	WCB, AC								
	b) Improve awareness among stakeholders of the availability of the Appeals Advisor service through better communication and promotion.	WCB, AC								

Acknowledgement

Some well-deserved acknowledgement is in order for all those who contributed to this review. Our primary sources of data were the WCB and the AC. The review team had access to the leadership teams in both the organizations, and they supported our enquiries and facilitated contacts for data collection. The consulting team also appreciates the sponsorship and clarity of direction that the team from the Ministry of Labour and Immigration provided, without which the review could not have been concluded successfully. Finally, the jurisdictional scan could not have been completed without the generous cooperation of personnel from the WCBs in British Columbia, Saskatchewan, Manitoba, and Ontario.

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Appendix

Appendix - 1: Glossary of Terms

1. Glossary of Terms

1.1 Alberta Context

Term	Abbreviation	Definition
Advisor Office	AO	The office that delivers the Appeals Advisor service.
Alternative Dispute Resolution	ADR	A collection of dispute resolution mechanisms that utilize an incremental, holistic, and simplified approach to dispute resolution, without the use of litigation.
Appeals Advisors	AA	Government funded positions in the Advisors Office that provide free advice and representation to workers and employers during dispute resolution within the WCB system.
Appeals Commission	AC	A quasi-judicial tribunal, independent from the WCB. The final level of appeal for workers and employers in Alberta workers' compensation system.
Appeals Officer	AO	Assigned to a claim after intake in the Appeals Commission. Single point of contact for the appellant and serves as a case manager.
Business Process Specialist	BPS	Receives and reviews the request for an Appeals Advisor service and conducts pre-assignment review of the file.
Case Conference with Outside Physician	CCOP	A phone call between the WCB Medical Consultant and the worker's Treating Physician to discuss the worker's medical information related to an injury.
Chief Administrative Officer	CAO	Administrative head responsible for the Medical Panel, Advisor Office and Secretariat branches within the Alberta Advisor Office. Reports directly to the Chief Appeals Commissioner.
Chief Appeals Commissioner	CAC	The head of the Appeals Commission and the Commissioner of the appeals tribunal in Alberta.
Claim Owner	CO	Responsible for claims processing and adjudication.
Customer Services Division	CSD	Organizational unit in Alberta WCB that administers all claims for compensation.
Dispute Resolution and Decision Review Body	DRDRB	First level of formal dispute resolution within Alberta WCB as required by legislation.
Employer Advisor Branch	EAB	Organizational unit in Alberta Advisor Office that provides advise and representation to employers in the appeal process.

Employer Appeals Consulting Service	EAC	Service provided by WCB, provides consultation to employers but does not represent the employer in the appeal process.
Fair Practice Office	FPO	Former organization in Alberta responsible for fairness review, appeals advisory and system navigation services.
Freedom of Information and Protection of Privacy Act	FOIP	Legislation in Alberta that guides the collection, use and disclosure of personal information by public bodies.
Independent Medical Examination	IME	Where a qualified physician, external to the WCB, examines and reports on the worker's condition.
Medical Consultant	MC	A qualified physician who provides medical opinion to a Claim Owner.
Medical Information Package	MIP	Set of medical history and report of the worker created by WCB for the Medical Panel.
Medical Panel	MP	A three-member external tribunal of medical experts that makes final and binding decisions on medical matters when requested by WCB or AC
Medical Panel Commissioner	MPC	Head of the Medical Panel and responsible for the selection of the medical panel and coordination of the medical hearing.
Notice of Appeal	NoA	Submitted by the worker or employer when they are not satisfied with the decision made by the DRDRB in Alberta. Begins the process in the Appeals Commission.
Preliminary Consultation Review	PCR	A service provided by the DRDRB to the Claim Owner when they are reconsidering their own decision at the request of the worker.
Quality Assurance	QA	Set of tools and tests used to assess if a system and service meets predetermined standards.
Representative		Persons who provide advice and representation to workers and employers during a dispute with the WCB. May be government funded (Appeals Advisors), fee for service practitioners (advocates, lawyers, etc.), family or a friend.
Resolution Specialist	RS	Role in the DRDRB responsible for reviewing decisions made by the Claim Owner when a dispute is referred to the DRDRB.
Request for Review	RFR	A formal application made by a worker or employer for the review of a decision made by a Claim Owner. Begins the informal dispute resolution process in Alberta.

Treating Physician	TP	Practicing physician, general practitioner or a family doctor who is providing medical advice or treatment to the worker for the injury.
Worker Advisor Branch	WAB	Organizational unit in Alberta Advisor Office that provides advise and representation to workers in the appeal process.
Workers' Compensation Act	WCA	Provincial legislation that regulates the Workers' Compensation System in Alberta.
Workers' Compensation Board	WCB	The organization responsible for administering the Workers' Compensation System in Alberta
Workers' Compensation System	WCS	The employer funded, no fault insurance program consisting of the WCB and the AC.

1.2 Jurisdictional Context

Term	Abbreviation	Definition
Appeals Commission	AC	A quasi-judicial tribunal, independent from the WCBMB. The final level of appeal for workers and employers in Manitoba workers' compensation system.
Appeals Department	AD	First level of appeal in the Saskatchewan workers compensation system. They provide an impartial, independent review process for claims relating to worker's injuries.
Appeals Resolution Officer	ARO	In Ontario, responsible for claims processing and adjudication during the review process.
Appeals Service Division	ASD	The first level of the formal appeal process in Ontario. Operates independently from primary claims adjudication and Case Managers.
Board Appeal Tribunal	BAT	A quasi-judicial tribunal, independent from the SWCB. The final level of appeal (excluding medical questions) for workers and employers in Saskatchewan workers' compensation system.
Claim Owner	CO	Responsible for claims processing and adjudication in British Columbia workers' compensation system.
Clinical Services Division	CSD	Division in British Columbia workers' compensation system that administers the Medical Advisors.
Employers' Appeals Office	EAO	Office within British Columbia workers' compensation system that provides free, independent advice, education, and representation to employers.
Employer Resource Centre	ERC	Supports employers by providing educational materials and assistance navigating the workers' compensation system in Saskatchewan.
Employer Services Department	ESD	Department responsible for employer accounts in Saskatchewan workers compensation system.
Health Care Services	HCS	Department that administers Medical Officers in Saskatchewan workers' compensation system and Medical Advisors in Manitoba workers' compensation system.
Independent Health Professional	IHP	Provide a professional medical opinion to the Medial Panel during the British Columbia workers' compensation system dispute process.
Independent Medical Examination	IME	Where a qualified physician, external to the workers' compensation system in Manitoba, examines and reports on the worker's condition.

Medical and Return to Work Plan	MARP	Used within British Columbia workers' compensation system to assess and develop treatment plan for injured workers.
Medical Liaison Office	MLO	In Ontario, the organization responsible for conducting medical file reviews on cases with medical complexities prior to the appeal.
Multidisciplinary Assessment and Rehab Team	MDA	Teams of medical professionals used to assess workers' injury during a medical dispute in the Saskatchewan workers compensation system.
Medical Review Panel	MRP	An external tribunal of medical experts that makes final and binding decisions on medical matters when requested during the appeals process in both Manitoba and Saskatchewan worker compensation systems.
Office of the Workers' Advocate	OWA	Provides Workers' Advocates who are accessible and free of charge to injured workers and their dependents seeking advice regarding claims and/or appeals in the Saskatchewan workers' compensation system.
Review Office	RO	First level of appeal in the Manitoba workers' compensation system. Provides an impartial, independent review process for claims relating to worker's injuries.
Saskatchewan Workers' Compensation Board	SWCB	The organization responsible for administering the workers' compensation system in Saskatchewan.
Workers' Advisers Office	WAO	Provide free, independent advice, education, and representation to workers in the British Columbia workers' compensation system.
Workers' Compensation Appeals Tribunal	WCAT	A quasi-judicial tribunal, independent from WorkSafeBC. The final level of appeal for workers and employers in British Columbia workers' compensation system.
Workers' Compensation Board of Manitoba	WCBMB	The organization responsible for administering the workers' compensation system in Manitoba.
WorkSafeBC	WSBC	The organization responsible for administering the workers' compensation system in British Columbia.
Workplace Safety and Insurance Appeals Tribunal	WSIAT	A quasi-judicial tribunal, independent from the WSIB. The final level of appeal for workers and employers in Ontario workers' compensation system.
Workplace Safety and Insurance Board of Ontario	WSIB	The organization responsible for administering the workers' compensation system in Ontario

Appendix - 2: Principles of Alberta Workers' Compensation

PRINCIPLES OF ALBERTA WORKERS' COMPENSATION

BoD Resolution 2021/02/07 Date: March 22, 2021

The principles contained in Sir William Meredith's 1913 *Final Report* (see Appendix C) are the foundation of workers' compensation in Alberta. Since 1913, these principles have evolved to reflect changing conditions. The principles are intended to be a "living document" and will continue to evolve as circumstances necessitate.

Today, the Workers' Compensation Board-Alberta operates according to the following principles, **which apply to all workers and employers protected by the Alberta *Workers' Compensation Act (WCA)***. These principles provide direction to management in the development of policy and establish a frame of reference for the Board of Directors for policy decision-making. The principles also provide staff, management, our clients, and the general public with guidance on the interpretation and application of policy. The principles are intended to provide the "why" or philosophical basis behind the policies. The articulation of principles provides transparency and points of reference for all stakeholders so that policy decisions of the Board of Directors can be better understood.

SYSTEM

1. **Exclusive Jurisdiction**

   WCB has sole authority to determine all questions or matters arising under the *WCA*, subject only to review and appeal.

2. **No Fault Benefits**

   WCB assumes liability for the injury in work-related circumstances despite the presence of fault on the part of a worker or employer.

3. **Protection from Lawsuit**

   Protection from lawsuit applies where the activities causing the injury are part of an employer's normal insured activities. Workers' compensation is meant to replace any tort remedy for that injury.

4. **Employer Financing of System**

   Employers are required to pay the full cost of the system through premiums.

5. **Neutral Administrator**

   WCB is a neutral and autonomous administrator of the workers' compensation system and strives to balance the interests of workers and employers.

6. Fairness

Decision-making is based on evidence, law, and policy, and a fair, impartial, and transparent process.

7. Promoting Prevention

WCB will offer pricing programs to employers that encourage safer workplaces and promote disability management.

FINANCIAL/PREMIUM

8. Balance Between Collective Liability and Individual Accountability

The premium structure should reflect a balance between collective liability and individual employer accountability.

9. Full Funding

The funding of the workers' compensation system must ensure there are sufficient funds on hand to meet present and future liabilities. Furthermore, the objectives of funding should be to minimize the risk of being unfunded, cost volatility, and overall cost to employers, while ensuring intergenerational equity among employers.

BENEFIT

10. Work-Relatedness

WCB determines whether the injury or illness is caused by work and compensates accordingly.

11. Focus on Safe Return to Work

The system should focus on safely restoring an injured worker, through return-to-work services, to a level of competitive employability.

12. Retrospective Earnings

The worker's historical earnings (up to any prescribed maximum in effect at the date of the accident) form the basis of the compensation rate, which is a percentage of the earnings, recognizing deductions that workers normally pay and encouraging return-to-work.

13. Maximum Compensable Earnings

The Board of Directors sets maximum compensable earnings annually to achieve coverage for the full wages of at least 90 per cent of workers in the province. The annual amount will change when the percentage of workers covered drops below 90 per cent.

14. Health Care

WCB decides the nature, sufficiency, and cost of health care, bearing in mind individual needs and medical efficacy.

15. Quality of Life for Severely Injured Workers

WCB should take reasonable measures to maintain a reasonable quality of life for severely injured workers through the provision of services allowed by legislation and policy.

16. Survivor Benefits

Survivor benefits should make reasonable provision for the spouse, adult interdependent partner and any dependent children of the deceased worker.

Previous versions

- Principles - September 2018
- Principles - April 2018
- Principles - August 2015
- Principles - March 2014
- Principles - January 2004
- Principles - February 2002
- Principles - February 1997

Appendix - 3: WCB Code of Rights and Conduct

CODE OF RIGHTS AND CONDUCT

BoD Resolution 2021/02/11 Date: March 22, 2021

REFERENCE: *Workers' Compensation Act, RSA 2000, Sections 9.2, 23.1, and 23.2*

Established under the authority of s.9.2 of the *Workers' Compensation Act* (*WCA)*, the *Code of Rights and Conduct* (the Code) sets out the rights of workers and employers (including their authorized representatives), in their interactions with the Workers' Compensation Board-Alberta (WCB) and how WCB conducts itself to make sure those rights are recognized. The Code provides a formal means for workers and employers to raise service issues and concerns and sets out a range of possible outcomes when resolving them.

The Code deals with service issues and does not replace the current process for review and appeal of adjudicative and employer account decisions. For information about review and appeal, see G-2, *The Review and Appeal Process.*

The rights and obligations set out in this Code are in addition to any other rights and obligations under the *WCA*, any other enactment or the general law.

Rights and Conduct

Dignity and respect	You have the right to be treated with dignity and respect. WCB is committed to being honest and courteous in all our interactions, providing considerate treatment and recognizing individual needs, including cultural differences and beliefs.
Fairness and impartiality	You have the right to fair and impartial treatment in your interactions with WCB. We will listen to you and your views will be considered when making decisions that affect you. WCB will exercise fairness and impartiality in making determinations under the *WCA*.
Effective and timely communication	You have the right to effective communications. WCB will be open and honest when communicating with you, responding to questions and issues in a timely manner, and ensuring that information is provided in an accessible form that meets your individual needs.
Full and correct information	You have the right to full and correct information in your interactions with WCB. Our goal is to keep you fully informed, ensuring you have the information you need regarding services, entitlements, and responsibilities.

Access to information You have the right to examine all relevant documents when a decision directly affects your interests. We will ensure you are aware of your rights and will assist you in accessing the information you need. See Policy 01-02, Part I and Part II, Applications 1 and 2, *Access and Privacy* for more information.

Privacy and confidentiality You have the right to privacy and confidentiality. Information given to WCB will be used only for the purposes allowed by the *WCA*, and the *Freedom of Information and Protection of Privacy Act.* For more information, see Policy 01-02, Part I and Part II, Applications 1 and 2, *Access and Privacy.*

Service issues and concerns

WCB is committed to following the Code when working with you, but we recognize that service concerns can arise. Here are the steps to follow when you have a service issue or concern (these steps differ from those used to resolve claim and account decision concerns):

Step 1: We know it can be difficult to talk to people about service concerns and that's why our first step is for you to share your concerns with the supervisor of the person providing the service. This may be all that is needed to resolve an issue, but if you still have concerns, move on to Step 2.

Step 2: If you are unable to resolve your concern with the supervisor, share your concern with the manager. The manager will work with you and your claim or account team to address your concerns (see *Resolutions and outcomes*, below).

Step 3: If you are still not satisfied with the response you receive to your service concern, you may notify the Fairness Review Officer by contacting the Fair Process Review Centre.

As part of WCB's commitments under the Code, we will inform you of the steps that have been taken to address your service issues and what next steps, if any, are available to you.

Resolutions and outcomes

In the event of a breach of the Code, WCB will address the issues with you. Resolutions will vary depending on the individual and the issue involved, but will typically include some or all of the following:

- meeting with you
- providing you with any relevant information
- providing a written summary and explanation
- providing a verbal or written apology

Discussions regarding breaches of the Code will focus on resolving the issue(s); financial remedies are not available.

Commitment to improve

WCB is committed to analyzing and monitoring issues arising from this process, identifying concerns with operational policies and processes, and undertaking necessary actions to improve systemic problems. For more information on reporting and WCB's commitment to improve the system for all stakeholders, see the *Fairness Review Mandate*.

Previous version

- Code of Rights and Conduct - December 2018
- Code of Rights and Conduct - September 2018

Appendix - 4: Questioning a WCB-Alberta Decision - Fact Sheet

Questioning a WCB-Alberta decision

WCB strives to make decisions that are fair, and it's important to us that you understand all of the decisions that affect your claim. If you would like to have a decision reviewed, please follow the collaborative review process.

The collaborative review process

1. Contact the person who made the decision (adjudicator or case manager)

- They will explain all of the considerations that went into making the decision.
- If there is any additional information that may change the decision, WCB will always consider it.

If there are still concerns then continue to step two of the review process.

2. Request a review

Complete this online form or you can request a paper version by calling toll-free at 1-866-922-9221.

Once WCB receives your request, a supervisor will work with you towards a possible resolution. This collaboration usually resolves most issues, but if you still have concerns, WCB will forward your request to the *Dispute Resolution and Decision Review Body*.

You must submit a request for review within one year from the date of the original decision.

If you are late submitting your request, you may apply in writing to the DRDRB to extend the time period. An extension of the time period may be granted when the DRDRB considers there is a justifiable reason for the delay.

Each case will be judged on its own merit, taking into consideration the reason for delay such as:

- You were unaware of the decision due to a lack of proper notice from WCB and you took reasonable and timely steps to file the request for review once you became aware of the decision.
- You relied on someone else that you trusted to file the request for review on your behalf, and once you became aware that the person had failed to file the request for review, you took reasonable and timely steps to file the request for review.
- You were unable to request a review due to diagnosed mental or physical incapacity or you were prevented from doing so because of some other valid reason.

You should submit documentation to support your reason for the delay. In considering whether to grant the extension or not, the DRDRB will consider your reason for the delay and the overall fairness of granting an extension.

In cases where an extension is granted, the DRDRB may outline conditions, such as the setting of deadlines for certain actions to be done.

3. Contact the Dispute Resolution and Decision Review Body (DRDRB)

Before reviewing your file, a review specialist will contact you to:

- Ensure they understand your specific issues and concerns.
- Determine your understanding of the decision.

DRDRB will ensure you have a clear opportunity to outline your issue before the specialist makes an assessment on your case. The review specialist will ask you to determine the best approach to resolve your issue. For example, a telephone/conference meeting may be recommended for more complicated cases that require an in-depth discussion of the decision with the parties involved. After that point, the specialist will review your file and mail a written decision to you once the review has been completed.

Appealing a DRDRB decision

If you are not satisfied with the results of our review process, you may appeal the DRDRB decision in through the Appeals Commission. If the DRDRB decision is dated prior to Sept. 1, 2018 you have one year to submit your written appeal to the Appeals Commission. If it is dated on or after Sept. 1, 2018, you have two years to submit your appeal.

Contact the Appeals Commission at:

Appeals Commission
Standard Life Centre
#1100, 10405 Jasper Ave.
Edmonton AB T5J 3N4
www.appealscommission.ab.ca

Your claim file

You may receive one copy of your claim at no charge. Simply call our Customer Contact Centre. Subsequent updates to your file are available at no charge.

Representation

You may acquire representation at any point throughout the review process. You must provide them with written permission to obtain your file and act as your representative. If you choose a lawyer or an advocate as your representative, you are responsible for their fees.

The following are questions you should ask before selecting a representative:

- What experience do you have with WCB-Alberta?
- Do you know and understand the *Workers' Compensation Act* and WCB's policies?
- What services do you provide?
- How much are your services?

Advisor Office

You may also request a representative from the Advisor Office. Services are available at any point of the review process and are free of charge.

Appendix - 5: WCB 2020 Year at a Glance

2020 year at a glance

	2020	2019
Number of workers covered	**1,710,729**	1,884,600
Registered employers	**162,449**	159,359
Lost-time claim rate (per 100 workers) [1]	**1.8**	1.6
Disabling-injury rate (per 100 workers) [1]	**2.7**	2.7
New claims reported	**107,588**	129,851
Lost-time claims [1]	**30,300**	30,100
Fatality claims accepted	**150**	165
Ineligible claims (% of all new claims)	**9.4%**	9.6%
New requests for review to the DRDRB	**2,186**	2,238
Return to work with accident employer	**94.0%**	94.2%
Return to work with new employer	**1.1%**	1.4%
Return to work overall	**95.1%**	95.6%
Estimated average claim duration (TTD days)	**59.6**	49.5
Cost-of-living adjustment on long-term benefits	**1.78%**	2.41%
Claim benefit expense (thousands)	**$1,208,788**	$1,246,444
New non-economic loss and permanent disability awards	**2,762**	3,063
New economic loss awards	**572**	677
Premium revenue (thousands)	**$1,074,149**	$1,124,225
Average collected premium rate (per $100 of assessable earnings)	**$1.13**	$1.08
Investment income (thousands)	**$1,087,603**	$1,474,477
Funded ratio (per cent funded)	**120.7%**	119.2%

[1] *Lost-time claims and the lost-time claim and disabling-injury rates are projected. This approach is taken to ensure claims for accidents occurring in 2020 but not reported by year-end are considered.*

Appendix - 6: WCS MAPR Guiding Principles

Alberta Workers' Compensation System
Medical and Appeals Performance Review
Guiding Principles and Priorities

1. The scope of the review includes all processes, sub-processes, roles and touchpoints related to both appeals and medical reviews that result in disagreement and dispute resolution in Alberta's workers' compensation system.

2. The review will be conducted with collaboration and transparency among the system agencies with the primary objective of finding process and cost efficiencies within medical review and appeals processes, without negatively impacting the experiences of, or services to injured workers and employers.

3. A holistic approach involving all the system stakeholders is crucial for improvements to be realized in a complex service like medical reviews and appeals, with multiple overlapping and interconnected processes.

4. It is understood that disputes arising from the adjudication of worker's compensation claims cannot be completely eliminated.

5. The review will evaluate the information and data collected from the stakeholder agencies along with the various perspectives of stakeholders. Conclusions and recommendations will be based on a thorough analysis of all the evidence collected.

6. The Meredith Principles are the basis for Canada's workers' compensation systems and will be a touchstone for recommendations from this review.

7. Early resolution and avoidance of disputes are desirable; however, they do not override the imperative for due process and fairness for all stakeholders in the system.

8. Recommendations from the review should not be constrained by legislation, regulations or operational policies existing at the time of this review.

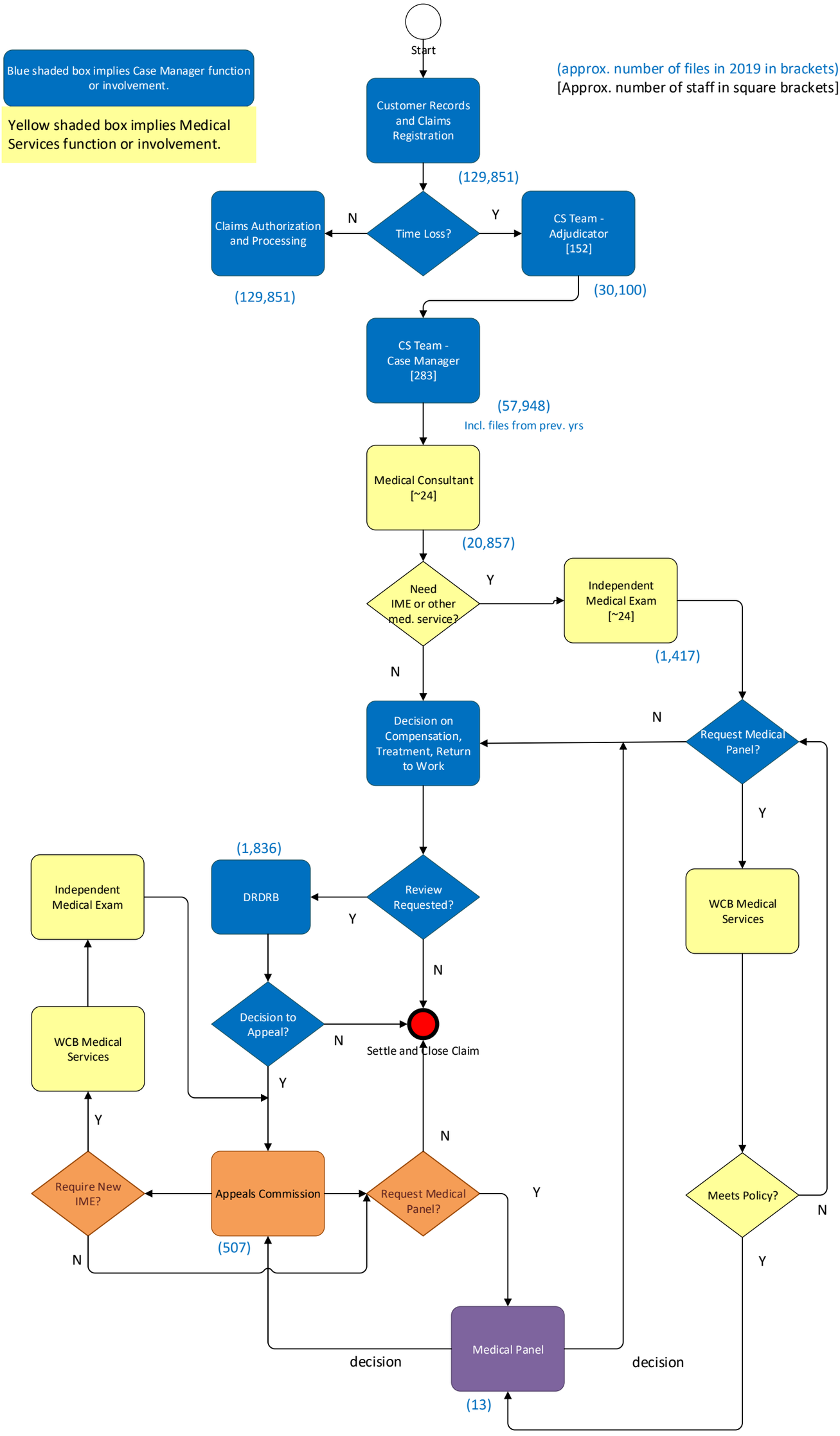
9. Recommended changes are to reflect leading practices while aiming to reduce red tape, and improve efficiency and responsiveness of the system.

10. Recommendations are intended to improve key outcomes, and depend on the extent to which the recommendations are implemented.

Appendix - 7: WCB Volume Flow in Claims Process

WCB Claims Management Process

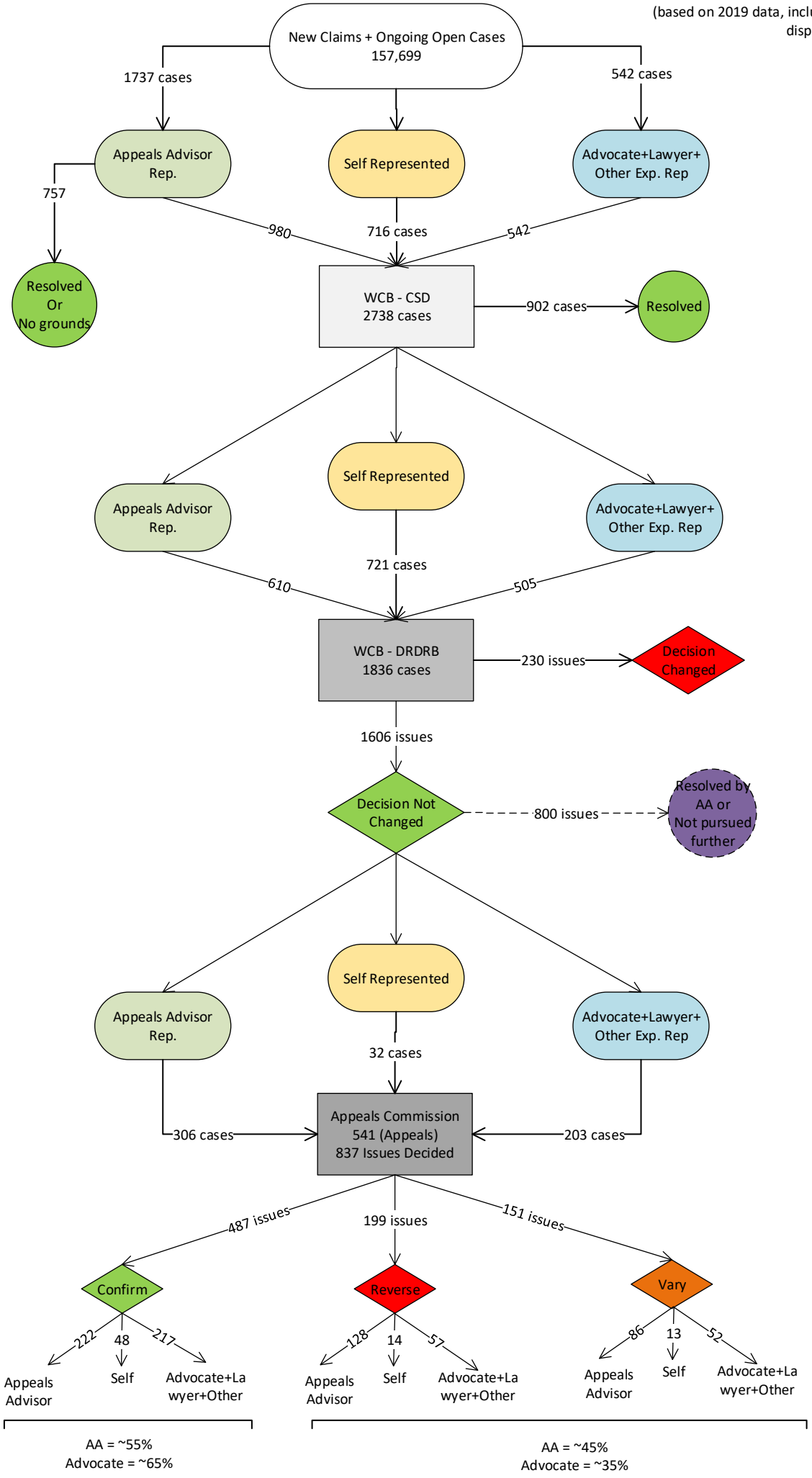
DRAFT



Appendix - 8: Dispute Volume Flow by Representation

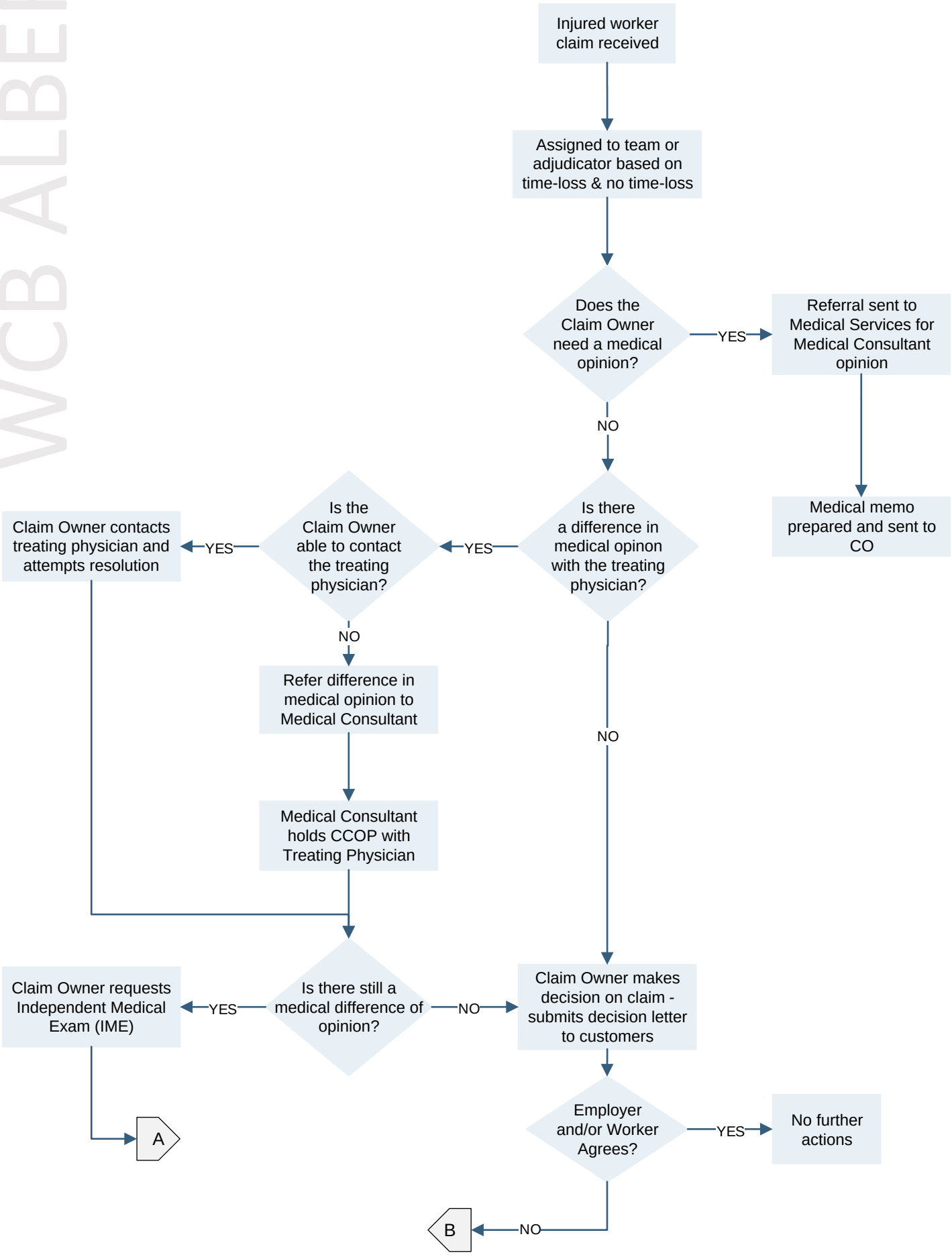
WCB Disputes Volume Flow with Representation

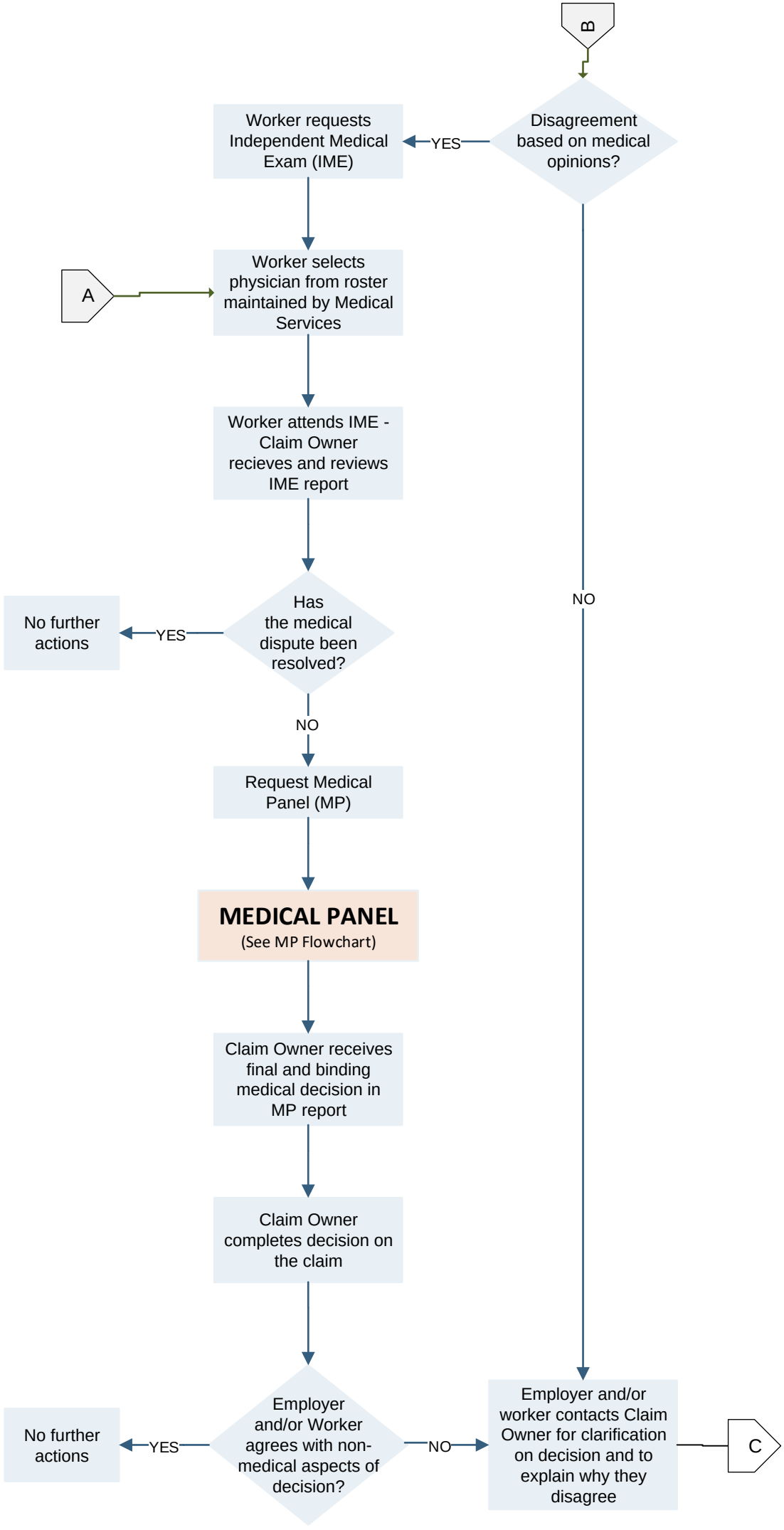
(based on 2019 data, includes worker and employer disputes)

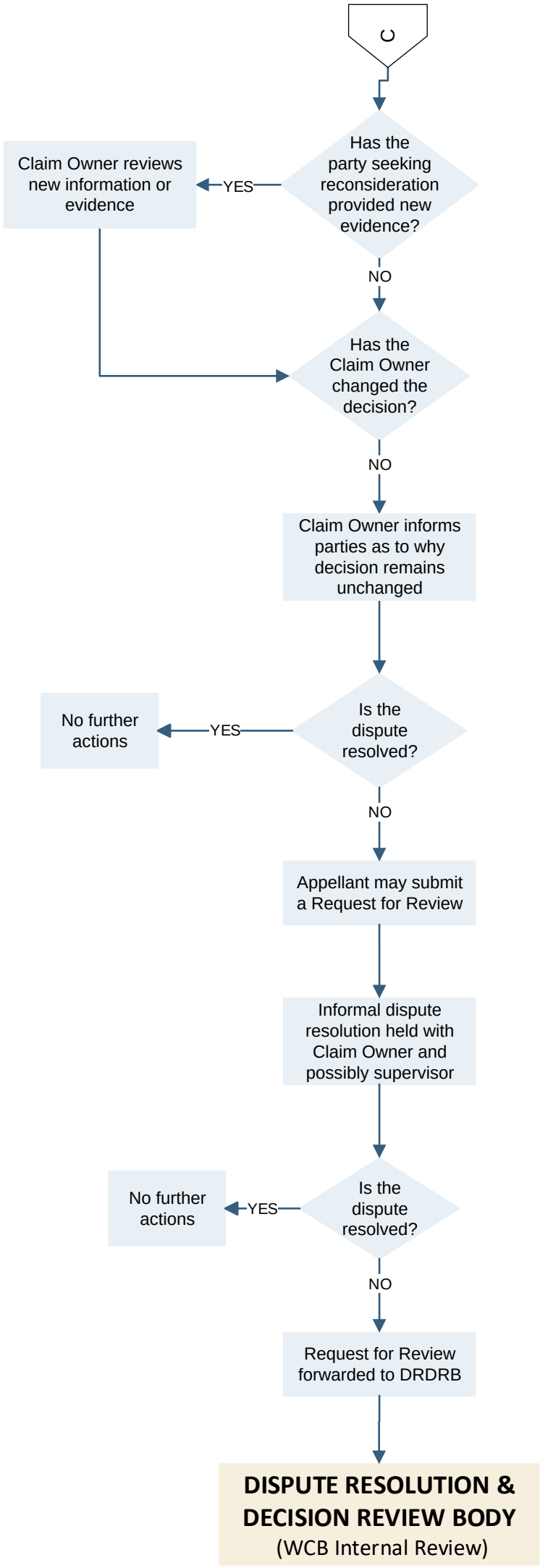


Appendix - 9: WCB Alberta Medical and Appeals Flowchart

CUSTOMER SERVICE
(CLAIMS ADJUDICATION)




B
Disagreement based on medical opinions?
YES
Worker requests Independent Medical Exam (IME)
NO
A
Worker selects physician from roster maintained by Medical Services
Worker attends IME - Claim Owner recieves and reviews IME report
Has the medical dispute been resolved?
YES
No further actions
NO
Request Medical Panel (MP)
MEDICAL PANEL
(See MP Flowchart)
Claim Owner receives final and binding medical decision in MP report
Claim Owner completes decision on the claim
Employer and/or Worker agrees with non-medical aspects of decision?
YES
No further actions
NO
Employer and/or worker contacts Claim Owner for clarification on decision and to explain why they disagree
C


C
Has the party seeking reconsideration provided new evidence?
YES
Claim Owner reviews new information or evidence
NO
Has the Claim Owner changed the decision?
NO
Claim Owner informs parties as to why decision remains unchanged
Is the dispute resolved?
YES
No further actions
NO
Appellant may submit a Request for Review
Informal dispute resolution held with Claim Owner and possibly supervisor
Is the dispute resolved?
YES
No further actions
NO
Request for Review forwarded to DRDRB
DISPUTE RESOLUTION & DECISION REVIEW BODY
(WCB Internal Review)

WCB ALBERTA

DISPUTE RESOLUTION & DECISION REVIEW BODY

(WCB Internal Review)

Time Limits:
Appellant has 1 year from the decision to request a review

Resolution Specialist assigned to Review

Is there any information or a decision missing from the file?

YES → File returns to Customer Service to complete missing items

NO

Resolution Specialist contacts appellant for their perspective

Appellant given choice of review format

HEARING

In person or video/ teleconfrence hearing - date decided

Other party invited to participate, unless relationship is strained

1-hour hearing occurs. Informal format focused on collaborative resolution

Following the hearing Resolution Specialist reviews the information

DOCUMENTS REVIEW

Documentary Review

Appellant has 2 weeks to submit further information

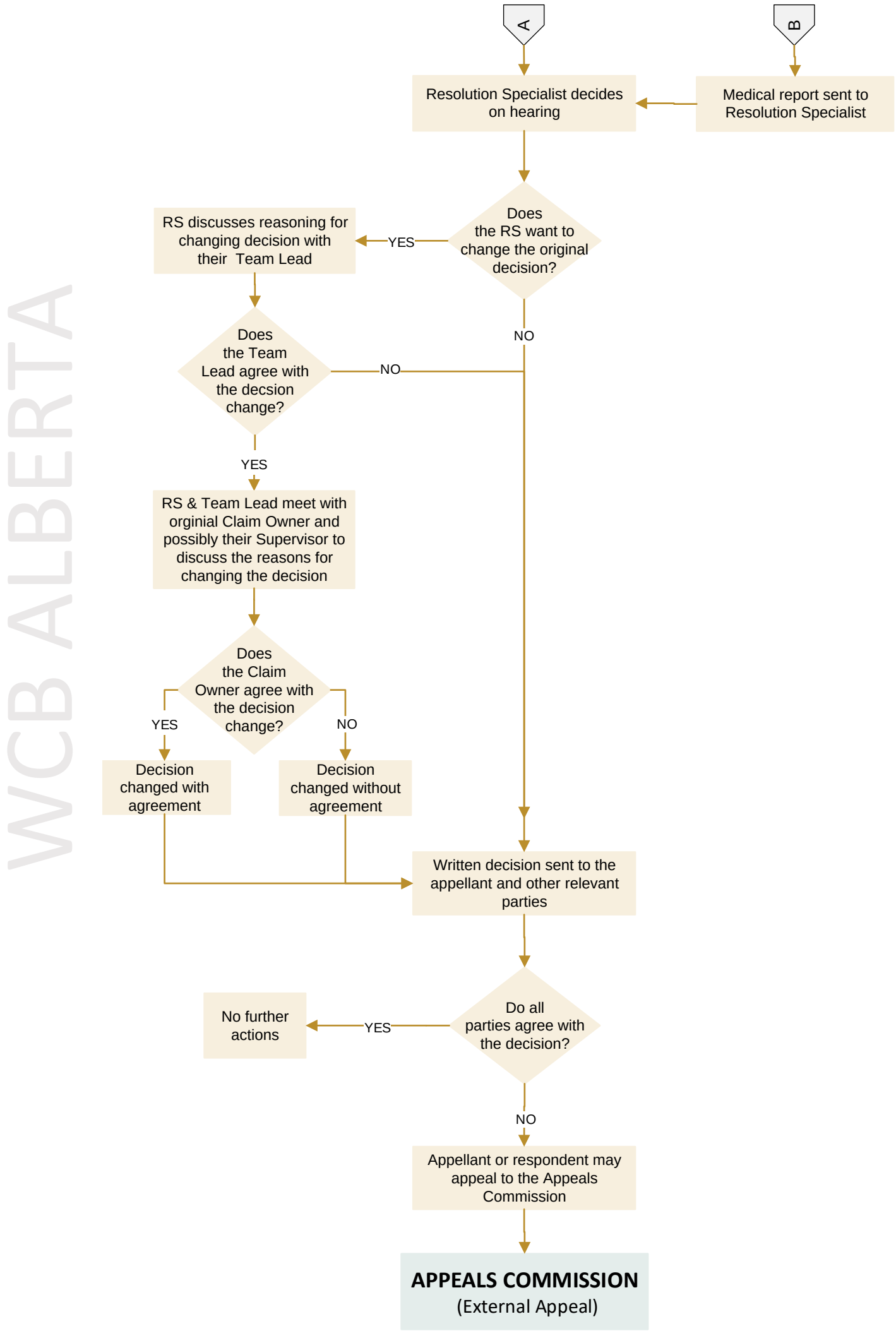
Information shared with other parties participating in review - they have 2 weeks to respond

Upon receipt of all submissions - Resolution Specialist completes a file review

Are there medical complexities requiring an IME or MP?

NO → A

YES → IME and/or MP completed following same pathway as identified in Claims and MP flowcharts → B


A
B
Resolution Specialist decides on hearing
Medical report sent to Resolution Specialist
Does the RS want to change the original decision?
YES
RS discusses reasoning for changing decision with their Team Lead
NO
Does the Team Lead agree with the decsion change?
NO
YES
RS & Team Lead meet with orginial Claim Owner and possibly their Supervisor to discuss the reasons for changing the decision
Does the Claim Owner agree with the decision change?
YES
NO
Decision changed with agreement
Decision changed without agreement
Written decision sent to the appellant and other relevant parties
Do all parties agree with the decision?
YES
No further actions
NO
Appellant or respondent may appeal to the Appeals Commission
APPEALS COMMISSION
(External Appeal)

WCB ALBERTA

APPEALS COMMISSION
(External Appeal)

The Appeals Commission receives the appellants Notice of Appeal - includes appellants preferred format

Time Limits:
1 year from the DRDRB decision to file an appeal

Receipt of appeal confirmed to appellant

Other parties notified of appeal - given 14 days to indicate their desire to participate

Hearing date selected

Appeal Documents Package (ADP) is prepared - sent to all participants

Panel of one Chair and two Commissioners is appointed

Appellant idenfies format of appeal in Notice of Appeal

IN-PERSON

In-person or via tele/ videoconference

Each participant has an opportunity to present their case and respond to submissions

A

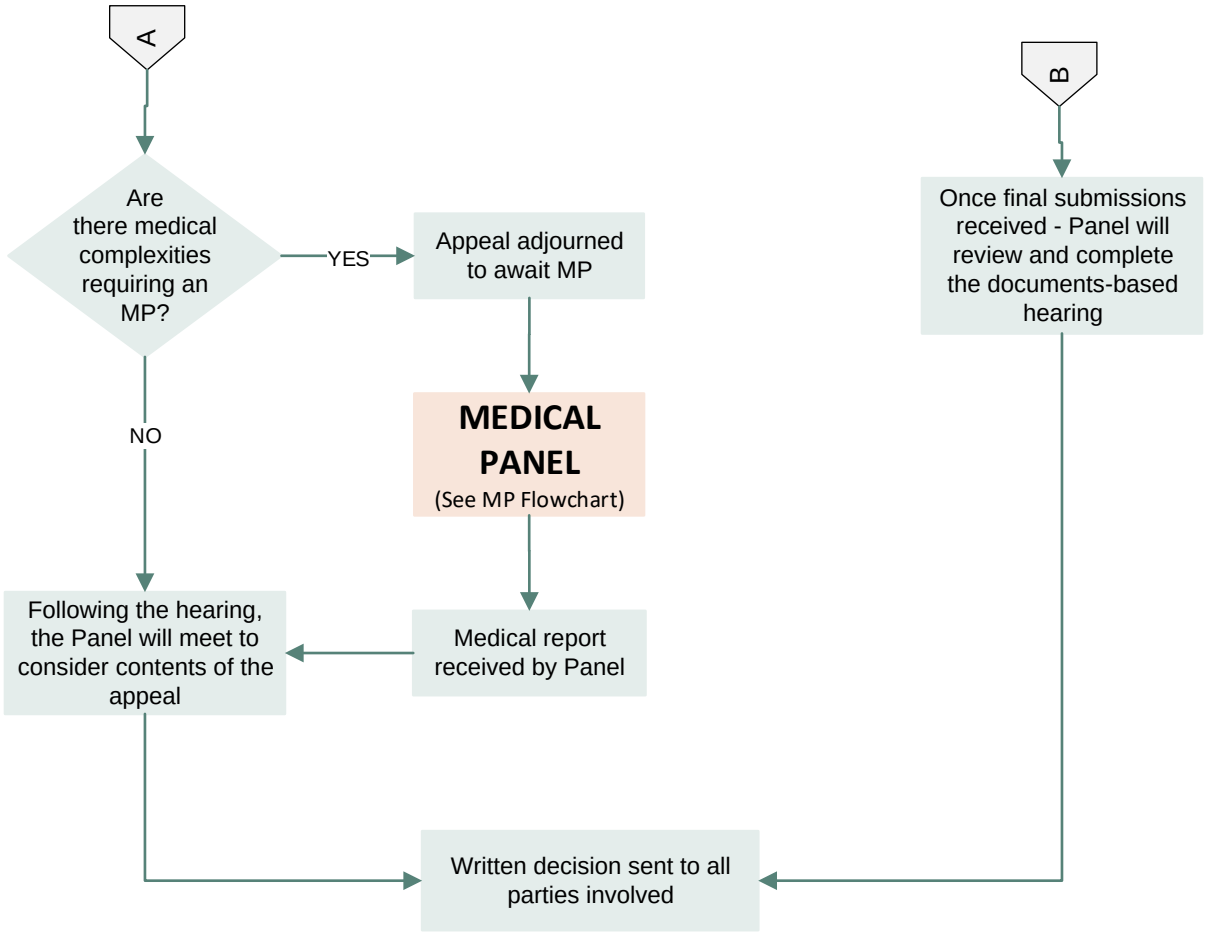
DOCUMENTS ONLY

Documents-Only Hearing - decided by review of ADP & additional submissions

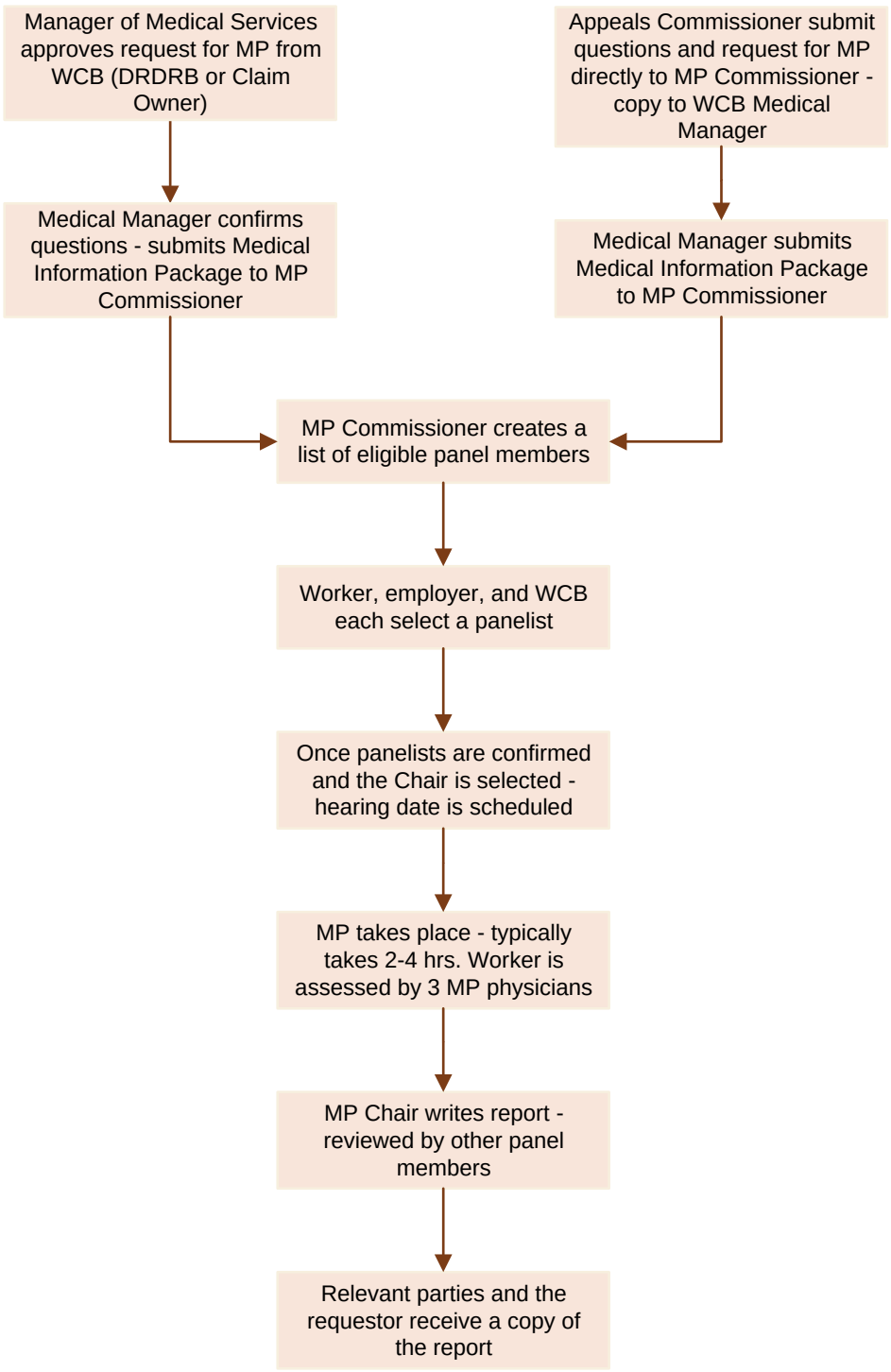
Participants given deadline for submissions

All submissions received by participating parties

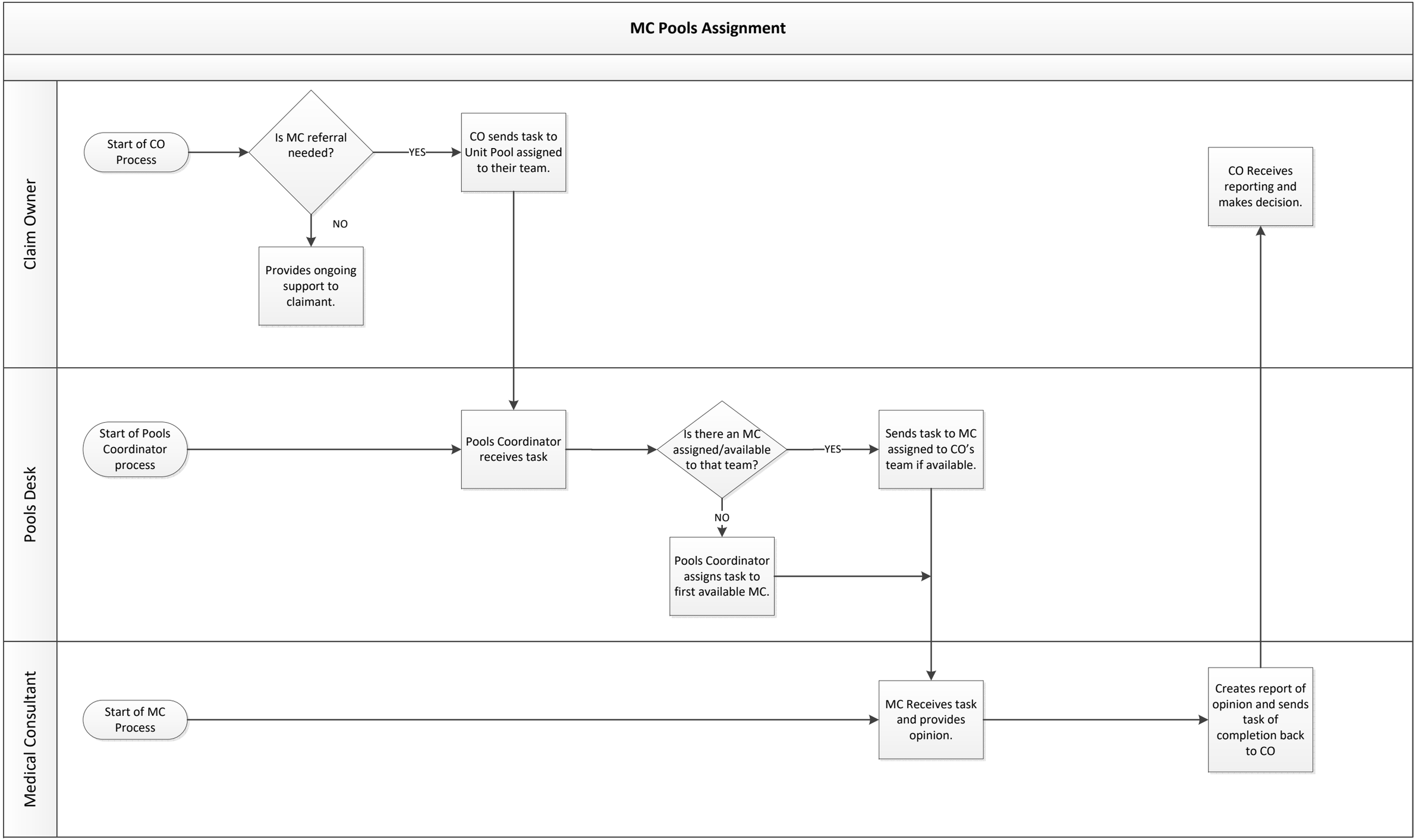
B


A
B
Are there medical complexities requiring an MP?
YES
NO
Appeal adjourned to await MP
MEDICAL PANEL
(See MP Flowchart)
Medical report received by Panel
Following the hearing, the Panel will meet to consider contents of the appeal
Once final submissions received - Panel will review and complete the documents-based hearing
Written decision sent to all parties involved

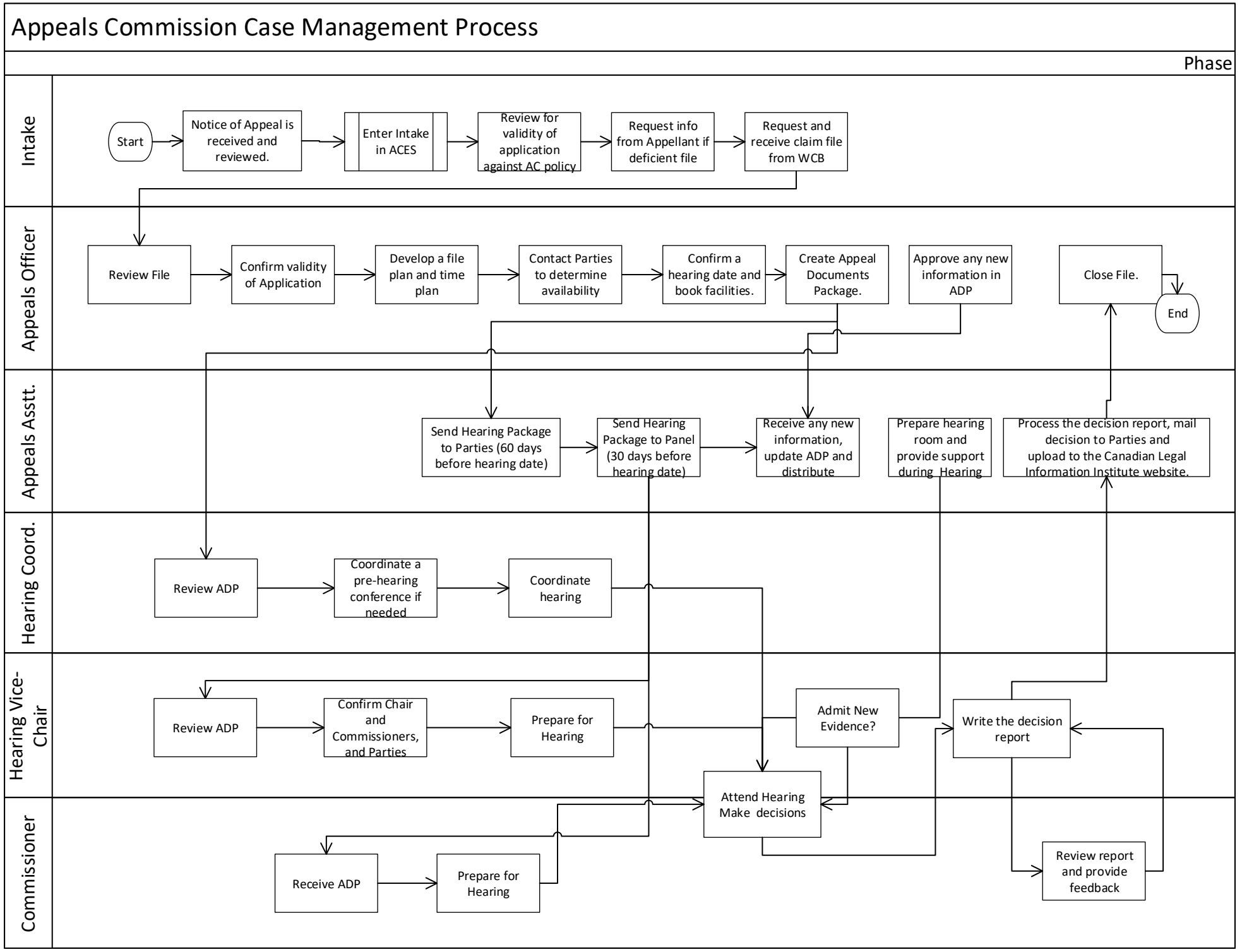
MEDICAL PANEL



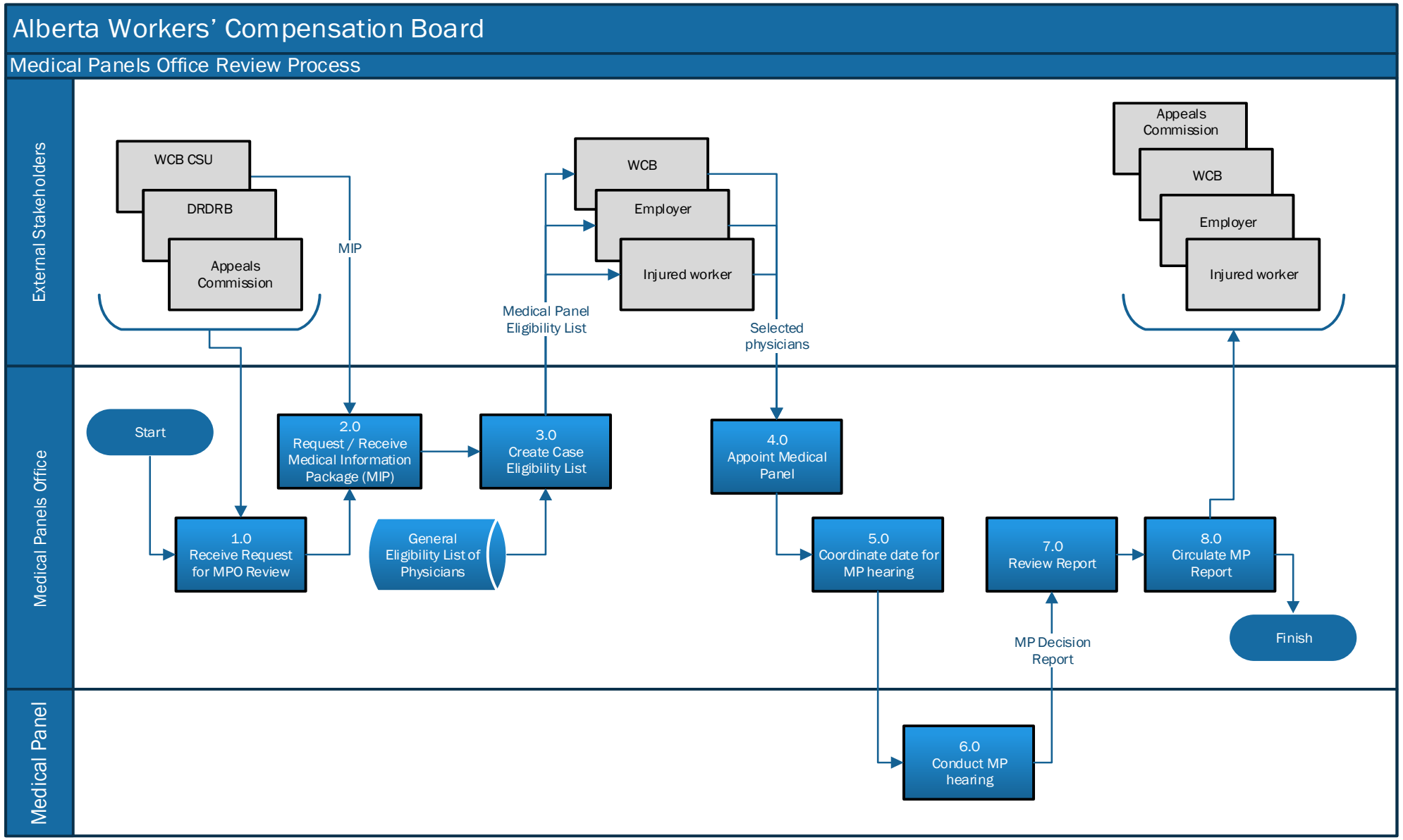
Appendix - 10: Medical Consultant Assignment Process


MC Pools Assignment
Claim Owner
Pools Desk
Medical Consultant
Start of CO Process
Is MC referral needed?
YES
NO
CO sends task to Unit Pool assigned to their team.
Provides ongoing support to claimant.
CO Receives reporting and makes decision.
Start of Pools Coordinator process
Pools Coordinator receives task
Is there an MC assigned/available to that team?
YES
NO
Sends task to MC assigned to CO's team if available.
Pools Coordinator assigns task to first available MC.
Start of MC Process
MC Receives task and provides opinion.
Creates report of opinion and sends task of completion back to CO

Appendix - 11: Appeals Commission Process

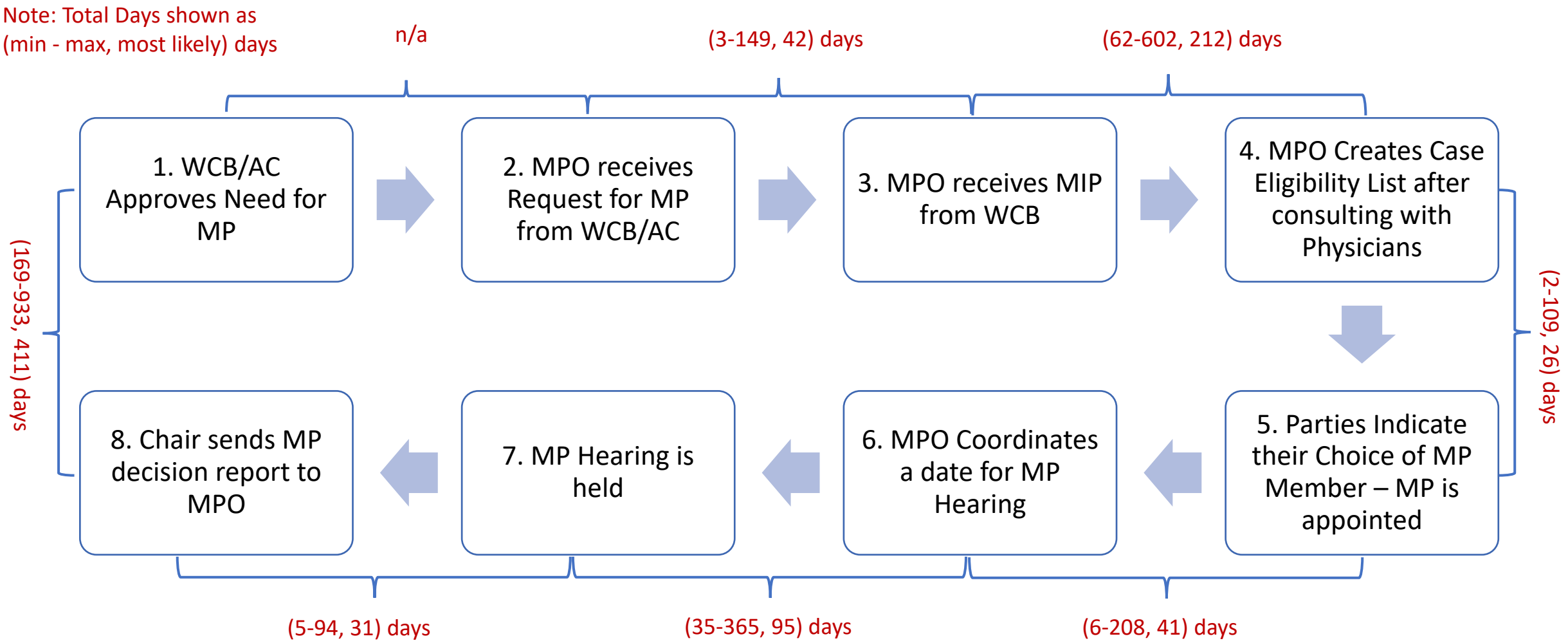

Appeals Commission Case Management Process
Phase
Intake
Start
Notice of Appeal is received and reviewed.
Enter Intake in ACES
Review for validity of application against AC policy
Request info from Appellant if deficient file
Request and receive claim file from WCB
Appeals Officer
Review File
Confirm validity of Application
Develop a file plan and time plan
Contact Parties to determine availability
Confirm a hearing date and book facilities.
Create Appeal Documents Package.
Approve any new information in ADP
Close File.
End
Appeals Asstt.
Send Hearing Package to Parties (60 days before hearing date)
Send Hearing Package to Panel (30 days before hearing date)
Receive any new information, update ADP and distribute
Prepare hearing room and provide support during Hearing
Process the decision report, mail decision to Parties and upload to the Canadian Legal Information Institute website.
Hearing Coord.
Review ADP
Coordinate a pre-hearing conference if needed
Coordinate hearing
Hearing Vice-Chair
Review ADP
Confirm Chair and Commissioners, and Parties
Prepare for Hearing
Admit New Evidence?
Write the decision report
Attend Hearing Make decisions
Commissioner
Receive ADP
Prepare for Hearing
Review report and provide feedback

Appendix - 12: Medical Panels Process


Alberta Workers' Compensation Board
Medical Panels Office Review Process
External Stakeholders
Medical Panels Office
Medical Panel
WCB CSU
DRDRB
Appeals Commission
MIP
WCB
Employer
Injured worker
Medical Panel Eligibility List
Selected physicians
Appeals Commission
WCB
Employer
Injured worker
Start
1.0 Receive Request for MPO Review
2.0 Request / Receive Medical Information Package (MIP)
General Eligibility List of Physicians
3.0 Create Case Eligibility List
4.0 Appoint Medical Panel
5.0 Coordinate date for MP hearing
6.0 Conduct MP hearing
7.0 Review Report
MP Decision Report
8.0 Circulate MP Report
Finish

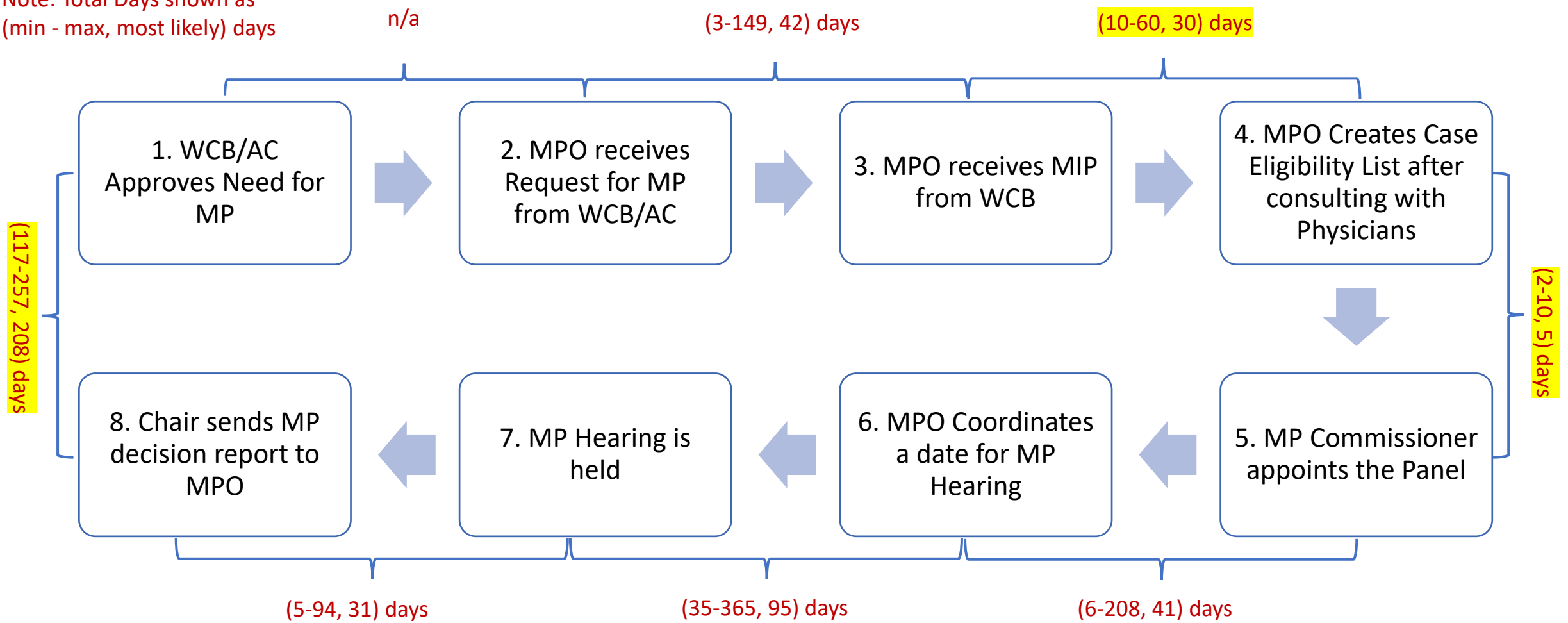
Appendix - 13: Medical Panels Conceptual Process

Elapsed Time in MP Process-Current



Elapsed Time in MP Process - Future

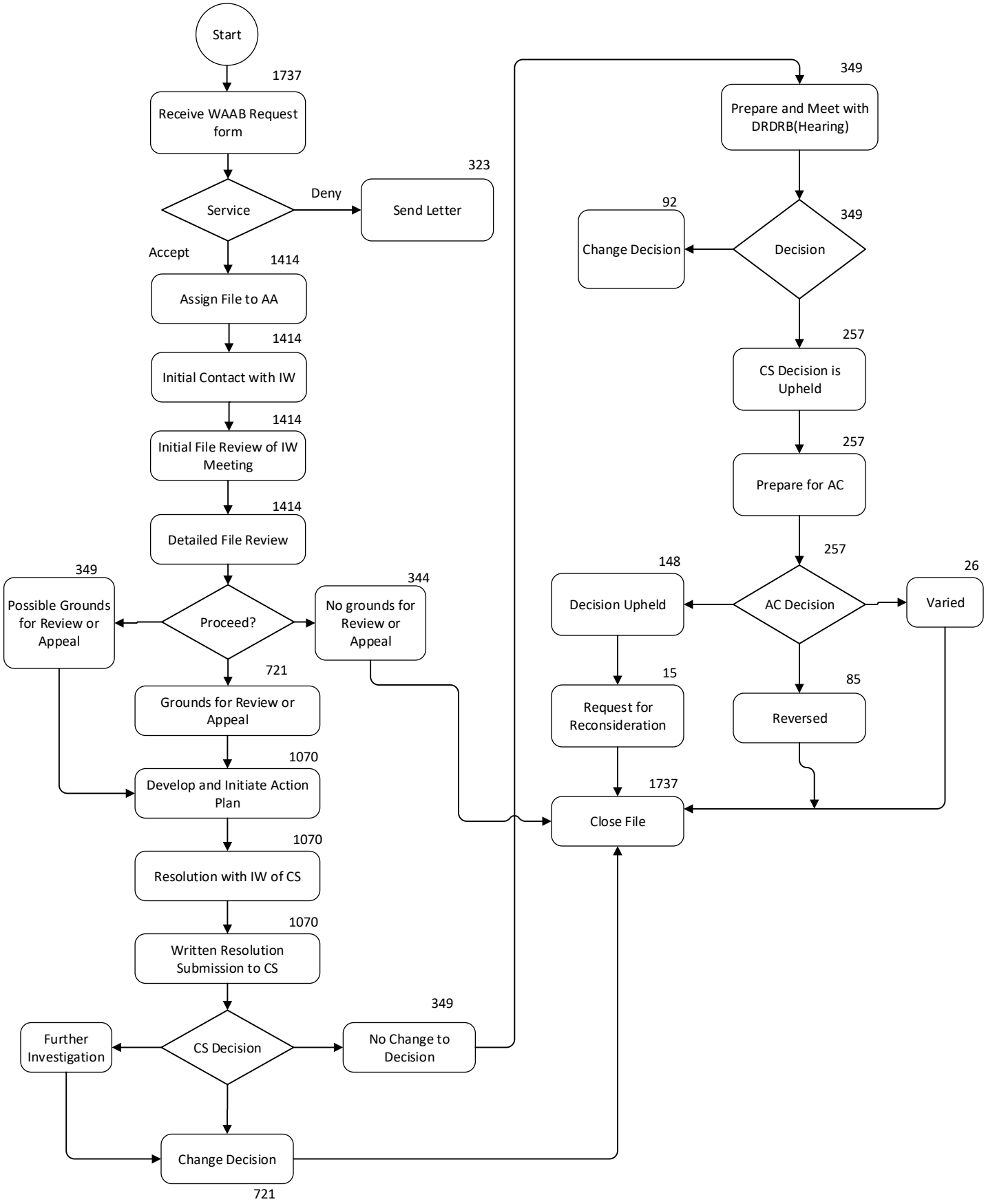
Note: Total Days shown as
(min - max, most likely) days



Appendix - 14: Appeals Advisor Conceptual Process

Worker Appeals Advisor - Casework

Note: numbers indicate count of clients/files for 2019-20. Some counts are estimates.



Appendix - 15: WCS Summary Operational Data

Alberta Worker Compensation System
Operational Data

Data	2018-19 (2018)	2019-20 (2019)	2020-21 (2020)
Workers insured	1,884,400	1,884,600	1,710,729
New Claims	132,346	129,851	107,588
New Time Loss Claims	27,599	30,100	30,300
Claims in Administration	178,377	178,346	157,669
MC Referrals	22,264	20,857	19,481
IME Referrals	1,298	1,417	1,178
MP Referrals	18	13	9
CSD Reviews	2,142	2,738	2,470
DRDRB RFRs	2,142	1,836	1,875
AC (initial appeal)	552	507	617

Note: WCB data is for 2019 calendar year, others are for 2019-20 fiscal year. AO budget is for 2020-21 year estimated.

Appendix - 16: WCS Detailed Operational Data

WCB Operational Data 2017-2019

CLAIMS REPORTED	AB
2017-2018: # of New Claims Reported	125,432
2018-2019: # of New Claims Reported	132,346
2019-2020: # of New Claims Reported	129,851

ACCEPTED CLAIMS	AB
2017-2018	
# of Claims Accepted	125,432
# of Time Loss Claims Accepted	25,858
% of Accepted Claims that are Time Loss	20.62%
2018-2019	
# of Claims Accepted	117,656
# of Time Loss Claims Accepted	27,599
% of Accepted Claims that are Time Loss	23.46%
2019-2020	
# of New Claims Accepted	117,385
# of New Time Loss Claims Accepted	30,100
% of Accepted Claims that are Time Loss	23.18%

2019-2020	AB
# of New Claims Reported	129,851
# of Claims Pending/Ongoing	27,848
# of New and Ongoing Claims	157,699
# of New Claims Accepted	117,385
# of New Claims Not Accepted	12,466
% of New claims disallowed	9.60%
# of Claims Pending or other at year end	33,490
% of Claims Pending at end of 2019	25.79%
Total # of potentially appealable claims	124,209

2019 Claims Administered	AB
New Lost-Time Claims	29,143
New medical-aid only claims	100,708
Total NEW claims reported	129,851
Active Claims as of January 1	33,490
Recurrent Claims	15,005
Total claims administered	178,346

Appendix - 17: DRDRB Operational Data

Review Body (DRDRB) Operational Data 2017-20

REVIEW INTAKE & OUTPUT	AB
2017-2018	
Incoming requests for review	2,343
Completed reviews	
2018-2019	
Incoming requests for review	2,142
Completed reviews	
2019-2020	
Incoming requests for review	1,836
Completed reviews	1,894
2020-2021	
Incoming requests for review	1,836
Completed reviews	1,875

CLAIMS THAT GO ON TO REQUEST A REVIEW	AB
2019-2020	
# of potentially appealable claims	129,851
Reviews as a % of claims received by WCB	1.41%
# of time loss claims accepted	30,100
Reviews as a % of claims received by WCB	6.10%
# of claims disallowed & accepted time loss	42,566
Reviews as a % of claims disallowed & accept. time loss	4.31%

REVIEW OUTCOMES - Issues	AB
2019-2020	
Changed/Overturned (Reviewer disagrees with orig. dec)	420
% Changed/Overturned	19.89%
Uphold (Reviewer agrees with orig. decisions)	1,692
% Confirm	80.11%
TOTAL	2,112
Return to Board	
TOTAL	2,112
2020-2021	
Changed/Overturned (Reviewer disagrees with orig. dec)	326
% Changed/Overturned	15.43%
Uphold (Reviewer agrees with orig. decisions)	1,787
% Confirm	84.57%
TOTAL	2,113

Appendix - 18: AC Operational Data

Appeal Commission Operational Data (2017-2019)

REVIEWS THAT GO ON TO REQUEST AN APPEAL	AB
2017-2018 (Apr 17-Mar 18 for AB)	
# of reviews received by the review department	
# of Appeals Received by appeals dept from review dept	710
Appeals as a % of reviews received by RD	
# of issues received	
2018-2019 (Apr 18-Mar 19 for AB)	
# of reviews received by the review department	
# of Appeals Received by appeals dept from review dept	552
Appeals as a % of reviews received by RD	
# of issues received	998
2019-2020 (Apr 19-Mar 20 for AB)	
# of reviews received by the review department	1,836
# of Appeals Received by appeals dept from review dept	507
Appeals as a % of reviews received by RD	27.61%
# of issues received	966

Total Appeals/Issues of Appeals	AB (from annual rep)
2017-2018 (Apr 17-Mar 18 for AB)	
# of Appeals Completed with a Decision	590
# of Issues Decided	799
2018-2019 (Apr 18-Mar 19 for AB)	
# of Appeals Completed with a Decision	619
# of Issues Decided	575
2019-2020 (Apr 19-Mar 20 for AB)	
# of Appeals Completed with a Decision	529
# of Issues Decided	814

DIRECT TO APPEALS CASES (No review) - 2019-2020		AB
Total # of Appeals Received	N/A	
Total # of Appeals that skipped the review dept.	N/A	
% of appeals that skip review dept.	N/A	

Number of days to decision	AB
2017-2018 (Apr 17-Mar 18 for AB)	264
2018-2019 (Apr 18-Mar 19 for AB)	181
2019-2020 (Apr 19-Mar 20 for AB)	216

# of Hearings By Type	AB
2017-2018 (Apr 17-Mar 18 for AB)	
Documentary Hearings	89

% Documentary	17.38%
In Person Hearings	423
% In Person	82.62%
Total # of Hearings	512
2018-2019 (Apr 18-Mar 19 for AB)	
Documentary Hearings	120
% Documentary	20.41%
Live Hearings (In-person, telecon, video con, combo)	468
% Live Hearings	79.59%
Total # of Hearings	588
2019-2020 (Apr 19-Mar 20 for AB)	
Documentary Hearings	103
% Documentary	25.06%
Live Hearings (In-person, telecon, video con, combo)	308
% Live Hearings	74.94%
Total # of Hearings	411

Appeal Participant Representative	**AB**
2017-2018 (Apr 17-Mar 18 for AB)	
Funded Advisor	299
% Funded Advisor	50.68%
Other Rep	231
% Other Rep	39.15%
Self Rep	60
% Self Rep	10.17%
2018-2019 (Apr 18-Mar 19 for AB)	
Funded Advisor	347
% Funded Advisor	56.06%
Other Rep	222
% Other Rep	35.86%
Self Rep	50
% Self Rep	8.08%
2019-2020 (Apr 19-Mar 20 for AB)	
Funded Advisor	290
% Funded Advisor	54.82%
Other Rep	206
% Other Rep	38.94%
Self Rep	33
% Self Rep	6.24%

Decisions on Appeal as a Whole	**AB**
2017-2018	
Reversed	151
% Reversed	25.53%

Varied	122
% Varied	20.65%
Confirmed	318
%Confirmed	53.82%
TOTAL APPEALS DECISIONS	590
2018-2019	
Reversed	319
% Reversed	27.05%
Varied	204
% Varied	17.25%
Confirmed	658
%Confirmed	55.71%
TOTAL APPEALS DECISIONS	1,181
2019-2020	
Reversed	114
% Reversed	23.96%
Varied	96
% Varied	20.15%
Confirmed	266
%Confirmed	55.90%
TOTAL APPEALS DECISIONS	475

Decisions on Issues of Appeal	**AB**
2017-2018	
Reversed	204
% Reversed	25.53%
Varied	165
% Varied	20.65%
Confirmed	430
%Confirmed	53.82%
TOTAL ISSUES OF APPEAL	799
2018-2019	
Reversed	218
% Reversed	27.05%
Varied	139
% Varied	17.25%
Confirmed	449
%Confirmed	55.71%
TOTAL ISSUES OF APPEAL	806
2019-2020	
Reversed	195
% Reversed	23.96%
Varied	164
% Varied	20.15%

Confirmed	455
%Confirmed	55.90%
TOTAL ISSUES OF APPEAL	814

Top 5 Issues of Appeal 2019-2020	**AB**
#1 Issue	Additional entitlement
Occurences	176
% of total issues	21.62%
#2 Issue	Acceptability of claim
Occurences	127
% of total issues	15.60%
#3 Issue	Temporary total disability
Occurences	95
% of total issues	11.67%
#4 Issue	Economic loss payment ca
Occurences	91
% of total issues	11.18%
#5 Issue	Rehabilitation services
Occurences	67
% of total issues	8.23%

Appendix - 19: AC Days to Hearing by Representation

Appeals Commission
Intake to Hearing Duration

Event Type	Initial

Days from Intake to Hearing

Average of Intake timeline	**Column Labels**		
Row Labels	**Decision Meeting**	**Hearing (Regular)**	**Special Motions Panel**
Appeals Advisor	304	301	127
Lawyer	342	271	243
Other – experienced	314	219	133
Other – inexperienced	161	189	110
Self-Represented	348	305	185
Overall Wtd. Average	**310**	**272**	**164**

Appendix - 20: Alberta WCS Performance Indicators

Performance Indicators (based on 2019 data)

Dispute Resolution Process	Indicator Description	Calculation	AB
I. CSD - ADR			
1	Total number of disputes (Resolution memos)	count of resolution memos from Aas, Advocates, Self-represented	2,738
2	Disputes (Res. Memos) per new Intake as %	count of Res Memo/Count of Intake	2%
3	Disputes per Lost-Time Claim as %	count of Res Memo/Count of Lost-time intake	9%
4	Disputes per Claim Open in Case Management as %	count of Res Memo/count of open cases	5%
II. Decision Review (DRDRB)			
1	Number of Requests for Review	New	1,836
2	RFRs per new intake	count of RFR/Count of Intake	1%
3	RFRs per Lost-Time Claim	count of RFR/Count of Lost-time intake	6%
4	RFRs per total open cases	count of RFR/count of open cases	3%
5	RFRs per Dispute in CSD	count of RFR/Count of Res. Memos	67%
6	RFRs per Res. Specialist FTE	Count of RFRs/FTE	118.45
7	Decisions per Res Specialist FTE	Count of decisions/FTE	122.2
8	Reviews returned to Board	% of reviews returned to previous decision-maker for further investigation	
9	Breakdown of Decision Types as % of Decisions (or RFRs) - Whole Review	Changed/Overturned/Vary (Reviewer disagrees with orig. dec, or 1 or more issue deci.)	19.89%
10		Uphold (Reviewer agrees with orig. decisions)	80.11%
11	Breakdown of Decision Types as % of Decisions (or RFRs) - Issues	Changed/Overturned/Vary (Reviewer disagrees with orig. dec, or 1 or more issue deci.)	19.89%
12		Uphold (Reviewer agrees with orig. decisions)	80.11%
13	Average number of days from RFR to Decision	count of days	40
14	Total Cost per RFR	Total budget/Count of RFR	$1,035
16	Approx. hours of effort per RFR per Res Spec.	RFR Completed/hrs worked per yr	15.34
III. Appeals Commission			
1	Hearings	% Documentary	25.06%

Dispute Resolution Process	Indicator Description	Calculation	AB
2		% In-Person	74.94%
3	NoAs per new claims intake	count of NoA/Count of Intake	0%
4	NoAs per Lost-Time Claim	count of NoA/Count of Lost-time intake	2%
5	NoAs per total open cases	count of NoA/count of open cases	1%
6	NoAs per Dispute in CSD	count of NoA/Count of Res. Memos	19%
7	NoA per RFR	count of NoA/Count of RFR	28%
8	NoAs per Commissioner FTE	Count of appeals decided/FTE	15.1
9	Issues per Commissoiner FTE	Count of issues decided/FTE	28.8
10	Breakdown of Decision Types as % of total Decisions (NoAs)	% Reversed	23.96%
		% Varied	20.15%
11		% Confirmed	55.90%
12	Breakdown of Decision Types as % of total Decisions on issues	% Reversed	23.96%
		% Varied	20.15%
13		% Confirmed	55.90%
14	Average number of days from NoA to Decision	count of days	216
15	Total Cost per Decisions (in-person and doc)	Total budget/Count of Decisions	$13,262
16	Total budget per Issue Decided	Total budget/Count of Issues	$13,262
17	Total budget per appeals decided	Budget/Appeal	$22,726
18	Total budget per Commissionner FTE	Total budget/Commissioner FTE	$322,235
19	Total Cost per FTE	Commissioner salaries/Total FTE	$124,672
20	Approx. hours of effort per NoA per Commissioner	# of appeals decisions/hrs worked per commisisoner per yr	123.89
IV. MC			
1	Number of Referrals to MC		20,857
2	Referrals per MC		993
3	MC Referrals per New Intake		16%
4	MC Referrals per Lost Time Claim		69%
5	MC Referrals per Claim in CaseMgmt(new Time Lost+Open from prev years)		36%
6	Number of opinion memos by type (verbal, written memo, PCI,)	Review & Call to Comm. Physician	3,788
		Written	14,626
		Verbal	3,149

Dispute Resolution Process	Indicator Description	Calculation	AB
		Written & Verbal	4,042
		TOTAL	25,605
7	Average cost per referral/memo	Total MC payments/number of referrals or memo	$144.19
8	Average days from Intake to MC Opinion		4
V. IME			
1	Number of IMEs		1,417
2	IME per MC Referral		7%
3	IME per Lost Time Claim		5%
4	IME per Claim in CaseMgmt(new Time Lost+Open from prev years)		2%
5	Average days from request to IME report		42
6	Cost per IME		$1,614.13
VI. MP			
1	Number of Medical Panels		13
3	Number of Questions		275
4	Total Cost per Panel	Total budget / number of medical panels	$87,835
5	Cost per Panel	cost of a med panel including panel member fees	$20,152
6	Average days from Intake to Panel Decision		223

Appendix - 21: Stakeholder Engagement

WCS-MAPR Stakeholder Engagement Plan for Project Planning and Data Gathering

Introduction

The Minister of Alberta Labour and Immigration has commissioned Engage First Management Consultants (EngageFirst) to complete a performance review of the medical review and appeals processes and services of the workers' compensation system. The Worker Compensation System – Medical and Appeals Performance Review (WCS-MAPR) will evaluate the effectiveness and efficiency of the existing services and processes, as well as explore opportunities for making services more efficient and effective in their mandates.

The primary objective of this review is to identify opportunities related to the delivery model for WCS's medical review and appeals services that will make them:

- more responsive to the needs of the stakeholders,
- streamlined, and
- more efficient and effective in achieving the desired outcomes for stakeholders.

Purpose of Stakeholder Engagements

Stakeholder consultations are the foundations on which a performance review like the WCS-MAPR project is based on. Stakeholders within the workers' compensation system and within the scope of this review will be engaged during the review so that the Consultant Team understands their views and perspectives, gets the information needed to understand the current situation, and to develop recommendations that are:

- Credible and Informed,
- Relevant and focused on the areas that matter most, and
- Evidence Based.

Effective stakeholder consultations and engagements provide benefits both in the short term (i.e. execution of the project), and in the long term by improving the chances of acceptance and successful implementation of the recommendations from the review. With our engagement approach, the stakeholders would:

- feel they had been heard, and that their input and perspectives have been considered by the Consultant Team,
- gain a better understanding of the review itself, and how it may make the system more effective and responsive to the stakeholders, and
- be assured that the recommendations are based on real challenges and opportunities that exist in the system based on their day to day lived experience.

Stakeholders

The following stakeholder organizations were approached for consultations, to gather information and data for the review.

1. Ministry of Labour and Immigration
2. Workers' Compensation Board
3. Appeals Commission of Alberta's Workers' Compensation Board
4. Fair Practices Office (FPO)
5. Medical Panels Office (MPO)

6. Industry Task Force
7. Labour Coalition
8. Alberta Ombudsman

Approach

Stakeholders with specific knowledge of the Medical and Appeals processes/functions were targeted during the engagement. Due to Covid-19 restrictions all interviews were conducted virtually. Some of the stakeholders may have been consulted multiple times to discuss various topics and to get further clarifications. The table that follows provides a list of stakeholders who were contacted.

The engagement was focused on fulfilling our information needs for the following two purposes:

Project Definition and Scope Clarification

The focus in this phase of the stakeholder engagements was to consult with senior leadership in the selected stakeholder organizations to help them understand the expectations and clarify the purpose of this performance review. We discussed if there were any ongoing initiatives related to these functions and their opinion on potential opportunities that they might recommend to be explored.

This engagement primarily occurred through interviews in the early phase of the project. The consultations did not preclude gathering information that would be considered data for the review.

Data Gathering and Discovery

The focus of this phase of the engagement was to gather information and data to support the consultant team's understanding of the current Medical and Appeals Services on topics such as:

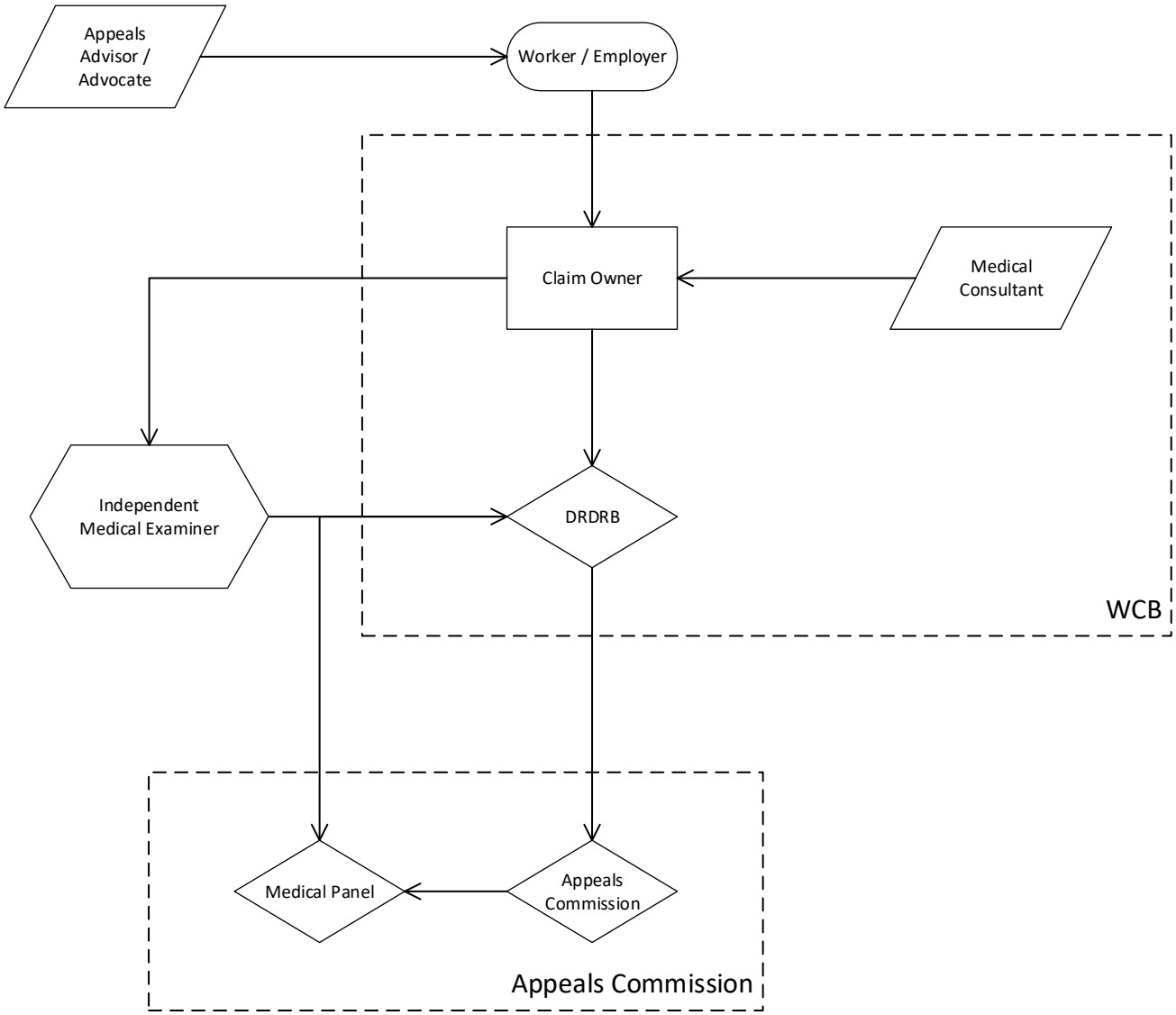
- Need of the Service
- Appropriateness of the Service Delivery Model
- Effectiveness of the Service
- Efficiency of the Service

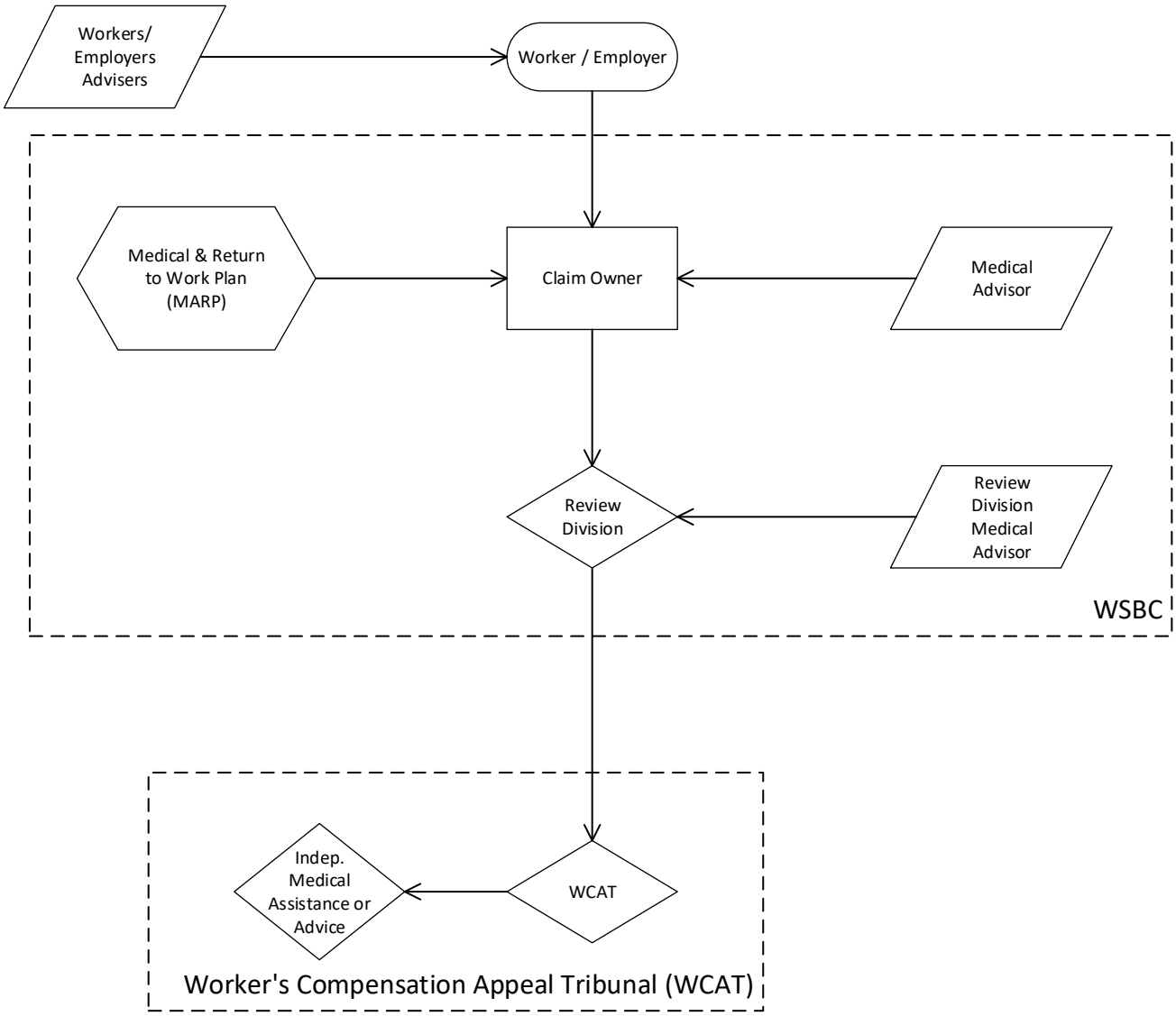
The information gathering was done in a combination of document review and interviews. Early in the process, we had collected several pieces of relevant information through a review of documents / reports provided by the stakeholders. The data collection included operational data, performance measures, and annual reports, relevant policies and processes to understand the stakeholder's role in the system. Individual interviews were conducted, primarily with management and staff in the organizations to gain further insight and clarify areas of potential opportunity identified through the initial document reviews.

WCS-MAPR
Stakeholder Consultation List

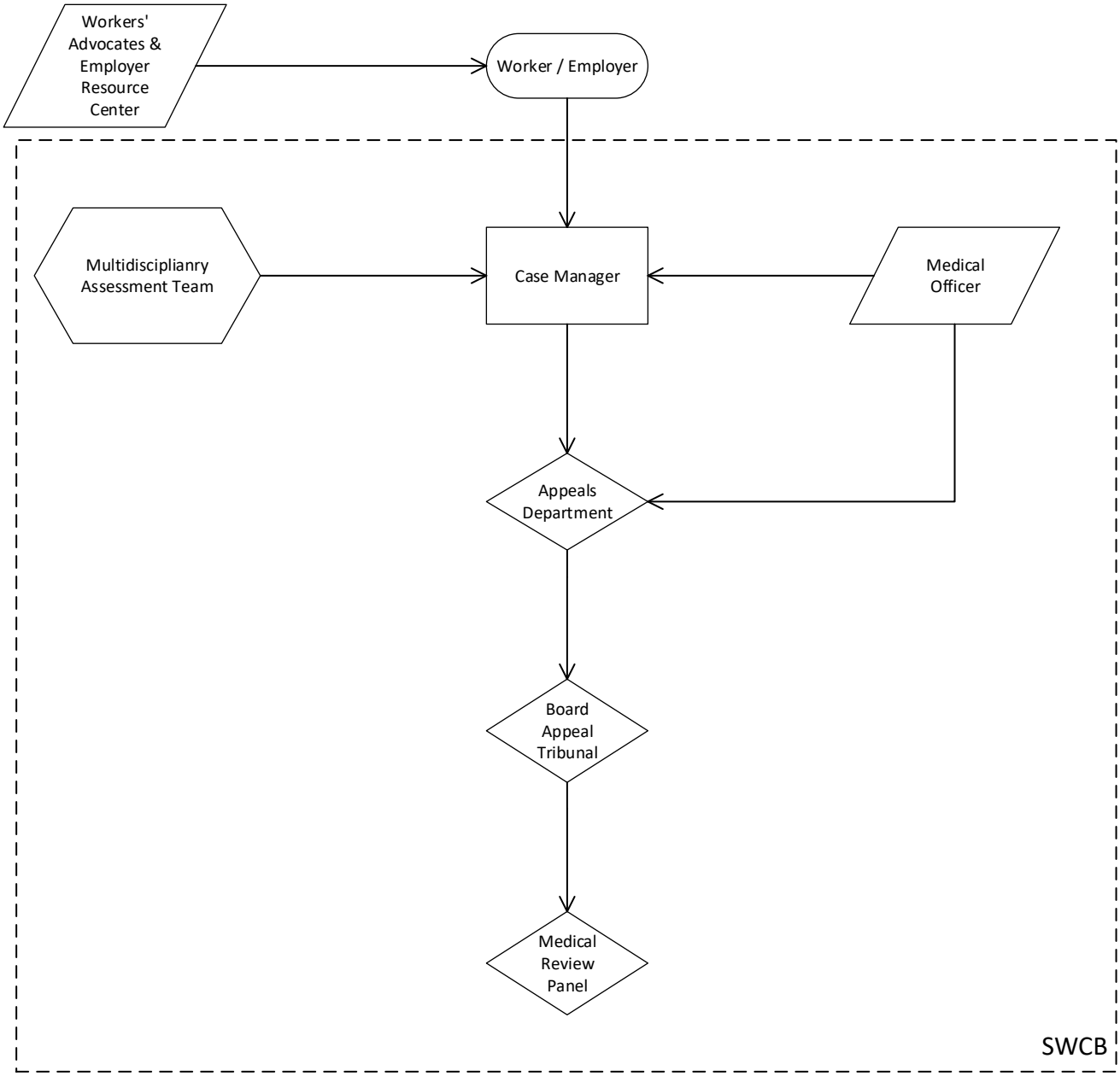
	Stakeholder Name, Title	Organization	Method	Purpose
Phase 1: Project Definition and Scope Clarification				
1	Trevor Alexander, CEO	WCB	Interview	• Understand their perception of the Medical and Appeals Services. • Understand and clarify expectation of what the Review should cover (scope). • Find out about any hotspots based on their knowledge that the Review should explore, where there are opportunities. • Get connected to information sources within their organization. • Share information on project approach, timelines, and outputs.
2	Wendy King, Sr. Vice President, COO	WCB	Interview	
3	Dale Wispinski, CEO & Chief Commissioner	AC	Interview	
4	Dr. Chris De Gara, Commissioner	MPO	Interview	
5	Harold Robinson, Commissioner	FPO	Interview	
6	Darren Ferleyko, President	ITF	Interview	
7	Liz Thompson, Chair	Labour Coalition	Interview	
Phase 2: Data Gathering and Discovery				
1	DRDRB, Chair	WCB	Interview	• Enquire on specific lines of investigation to meet the objectives of the Review. • Interview questions were prepared in advance and were shared with the interviewee. • Questions captured information on current challenges and potential best practices e.g. early identification and resolution, alternative approaches to resolution, and opportunities for efficiency in the system. • In addition to the interviews, data and reference documents were also requested from each source.
2	DRDRB, Team Lead	WCB	Interview	
3	DRDRB Resolution Specialist	WCB	Interview	
4	Customer Service Supervisor (3)	WCB	Interview	
5	Quality Assurance Specialist	WCB	Interview	
6	Director, Medical Services	WCB	Interview	
7	Chief Administrative Officer	AC	Interview	
8	Director, Advisor Office	AC	Interview	
9	Director, Medical Panels Office	MPO	Interview	
10	Appeals Officer	AC	Interview	
11	Worker Appeals Advisor (5)	AC	Interview	
12	Employer Appeal Advisor	AC	Interview	
13	Worker Advocate (2)		Interview	
14	Employer Advocate		Interview	
15	General Counsel	Alberta Ombudsman	Interview	
	Note: Brackets indicate number of people in the role (when more than one) who were interviewed.			

Appendix - 22: J-Scan Provincial High Level Process

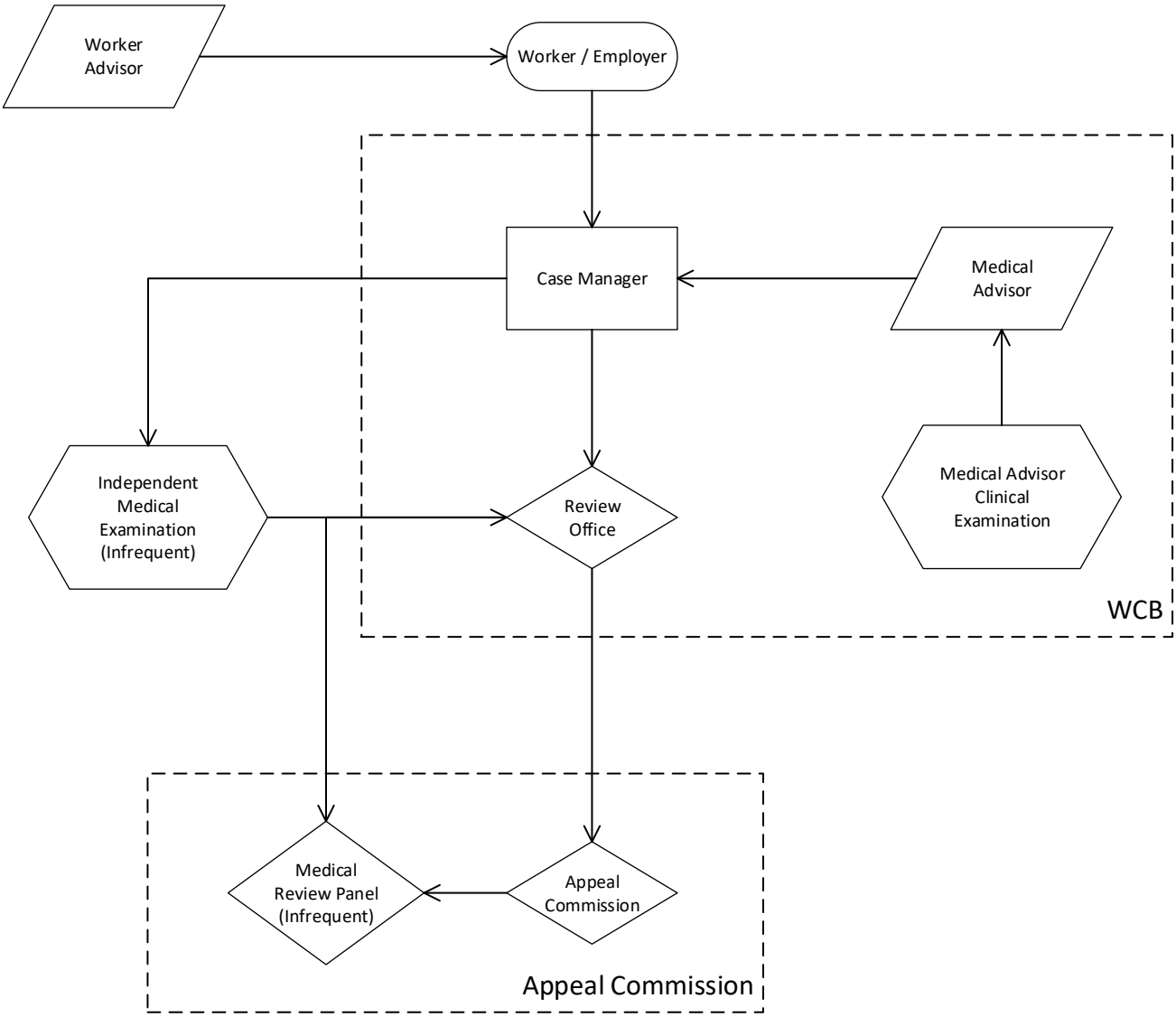

Appeals Advisor / Advocate
Worker / Employer
Claim Owner
Medical Consultant
Independent Medical Examiner
DRDRB
WCB
Medical Panel
Appeals Commission
Appeals Commission

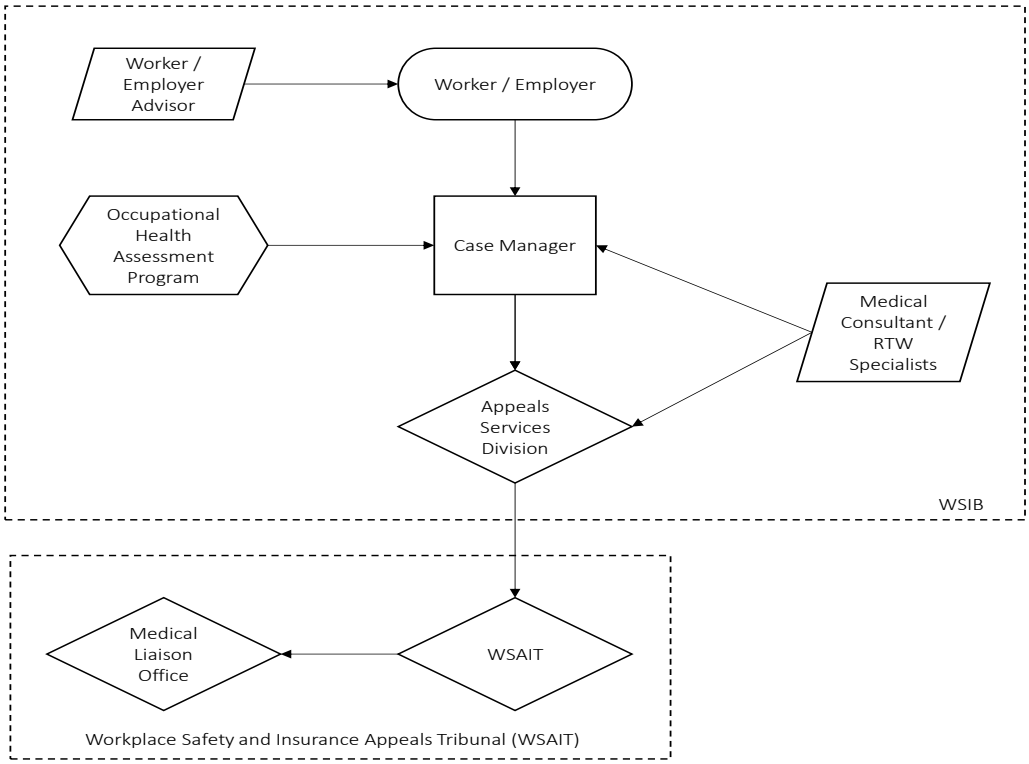

Workers/
Employers
Advisers
Worker / Employer
Medical & Return
to Work Plan
(MARP)
Claim Owner
Medical
Advisor
Review
Division
Review
Division
Medical
Advisor
WSBC
Indep.
Medical
Assistance or
Advice
WCAT
Worker's Compensation Appeal Tribunal (WCAT)

WCS Dispute Resolution in Saskatchewan



WCS Dispute Resolution in Manitoba




Worker / Employer Advisor
Worker / Employer
Occupational Health Assessment Program
Case Manager
Medical Consultant / RTW Specialists
Appeals Services Division
WSIB
Medical Liaison Office
WSAIT
Workplace Safety and Insurance Appeals Tribunal (WSAIT)

Appendix - 23: J-Scan Provincial WCS Summary

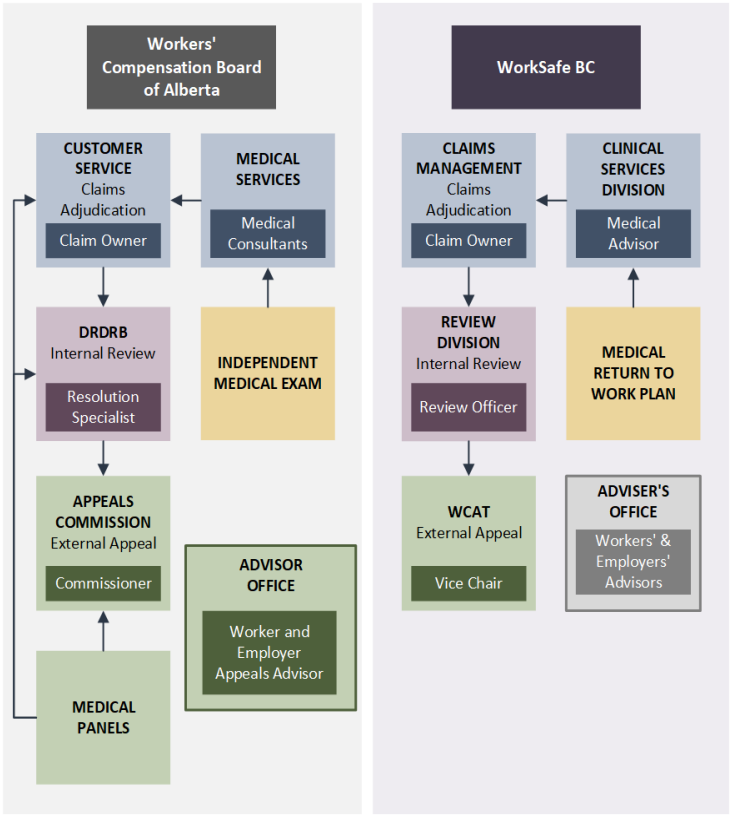
Jurisdictional Scan Provincial Summary

1. WorkSafe BC

1.1 System

The Claim Owner is responsible for processing and making decisions on injured worker claims. To enhance their decision-making capacity when considering a medical question, they have access to Medical Advisors.

Medical Advisors are located in the Clinical Services Division (CSD) in WSBC, with two thirds being permanent fulltime employees, and the remainder being contract. The primary function of the Medical Advisors is to provide independent medical information to Claim Owners regarding medical questions relating to the claimant's case. This may include treatment plans, medications, or suggested diagnostic measures.



Each level of resolution has their own QA team (Claims Management, Review Division, WCAT – Tribunal Office). While they individually conduct quality audits, they also regularly convene to discuss trends and high-level quality issues across all departments.

1.2 Claims Dispute Process

If a worker or employer disagrees with a Claims Management decision, they may request that the Claim Owner reconsider the claim within 75 days from the date of the decision, or they may proceed directly to the Review Division (RD) and request a review within 90 days from the date of the decision.

1.3 Review Division

The RD is organized within WSBC but functions independently. However, the RD is unique from other jurisdictions, as they can review employer occupational health and safety disputes in addition to compensation disputes. The RD reviews the decisions made by the Claim Owner and renders decisions that are final and

binding on all parties. Decisions by the RD concerning vocational rehabilitation benefits, certain permanent disabilities, and commutation of benefits, are all final and cannot go to WCAT, but a request for review by the Chief Review Officer can be made within 23 days of the decision.

Cases are decided by a single Review Officer and are primarily documents based. The review is conducted independently from Claims Management, and the Review Officer does not confer with the Claim Owner at any point during their review or decision making. Should the Review Officer require any medical advice, they have access to Medical Advisors who work solely for the RD.

1.4 The Worker's Compensation Appeal Tribunal

The WCAT is the final level of appeal for WSBC decisions. It operates independently from WSBC, similar to Alberta's AC. WCAT establishes panels of one to seven Vice Chairs to decide on the appeal. Most panels consist of a single Vice Chair while 3-member Panels are utilized for more complex claims. Three to 7-member panels are employed for claims whose outcomes are significant to the Workers' Compensation system. The Chair determines the method of the hearing, either an oral hearing (in-person/videoconference) or a written/document-based hearing.

Appellants have 90 days from the date of their RD decision to file for an appeal. Decisions by WCAT are final and conclusive but may qualify for reconsideration in the event there is new evidence or a proven jurisdictional error.

1.5 Medical Dispute Process

The Medical Advisor does not directly speak with or examine the injured worker. In the event there is a medical dispute, they can consult with the injured worker's treating physician (TP) to facilitate understanding of the medical issue(s) and promote collaboration. When a worker is off for longer than eight weeks, WSBC has a program in place where the Medical Advisors communicate with the worker's physician to enhance treatment and return to work planning.

WSBC does not have a formal IME process. In cases where the Medical Advisor recommends that the Claim Owner obtain further medical information based on physical examination, the Clinical Services Division will assist by identifying a qualified practitioner(s). For cases where the injured worker is not recovering or returning to work as expected, the Clinical Services Division has developed a Medical and Return to Work Plan (MARP) to provide the Claim Owner with an objective, hands on medical opinion.

There are no MPs in WSBC's review and appeal system. The only relatively comparable process is the Independent Health Professional (IHP) process conducted at the WCAT level. If the panel requires medical

assistance or advice, they may a designated independent health professionals from a list that is maintained by the Chair. However, they only provide a professional opinion and do not decide the medical dispute.

1.6 Appeals Advisor Services

WSBC has both a Workers' Advisers Office (WAO) and an Employers' Advisers Office (EAO) that provides free and independent advice, education, and representation to employers and workers. Worker Advisors may submit requests for review and represent workers and employers at the RD and/or WCAT. Both the Worker Advisor Office and Employer Advisor Office share offices in eight locations throughout BC. The offices are externally operated from WSBC.

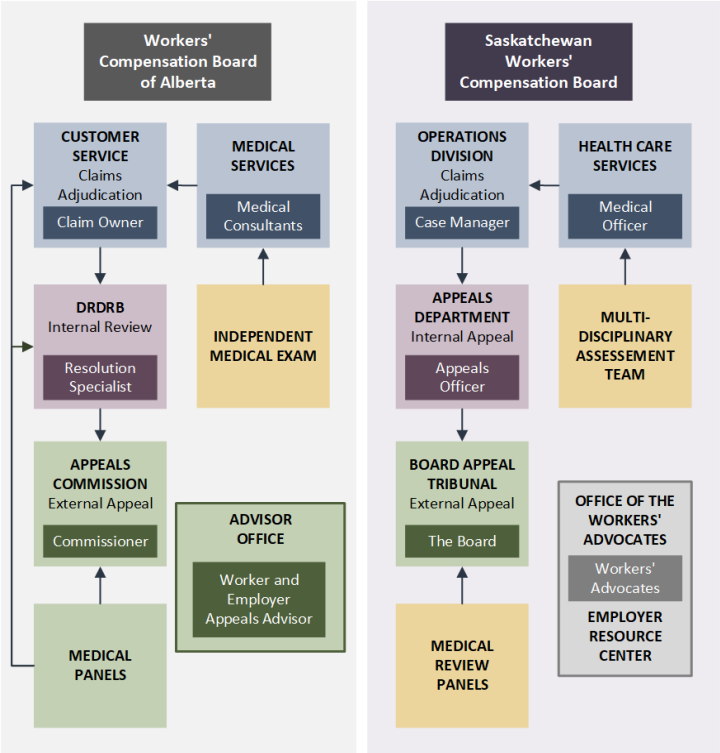
2. Saskatchewan Workers' Compensation Board

2.1 System

Decisions on employee injury claims are made by Case Managers in the Saskatchewan Workers' Compensation Board's Operations Division. For cases requiring medical advice, the Case Manager can consult with SWCB employed Medical Officers.

Medical Officers are organized within SWCB's Health Care Services (HCS) division and can provide Case Managers with independent medical opinions. Approximately half of the Medical Officers are permanent fulltime staff, while the remainder work as part time contractors.

Only the Operations Division completes QA, but it does not pertain to reviews and appeals. The Appeals Department (AD) does not have a QA process.



2.2 Claims Dispute Process

The Case Manager is solely responsible for claims decisions. If the injured worker or employer disagrees with the decision, they must first contact the Case Manager to discuss how the decision was made.

SWCB does not have an external appeal body, a feature that is unique to Saskatchewan. The two levels of appeal for disputes – AD and the Board Appeal Tribunal (BAT) – operate within SWCB. There are no time limits for appeals or reconsiderations.

2.3 Appeals Department

The first level of appeal is the AD which is internal to SWCB, where appeals undergo new adjudication by a single Appeals Officer. The Appeals Officer does not communicate with the original decision-making Case Manager other than to clarify information on the case file. If an Appeals Officer requires medical advice, they may request an opinion from one of the Medical Officers from the same pool of physicians as those utilized by the Operations Division.

2.4 Board Appeal Tribunal

Should the appellant disagree with the decision(s) made by the Appeals Officer, they may appeal to the BAT. The BAT is the highest level of appeal in SWCB, excluding medical questions, which are determined through a Medical Review Panel. Appeals are conducted by at least two of SWCB's three board members, which is a permanent body that decides all appeals. There are two formats for the appeal: Non-Hearing Appeal Process (document review) or Hearing Appeal Process (in-person hearing). Non-medical BAT rulings are final and binding.

2.5 Employer Services Department

Employers that want to appeal a decision made on their employee's claim may do so through the AD and BAT. Decisions relating to employer accounts go through the Employer Services Department (ESD). Employers can request a review by the Assessment Committee, and as a final step, the BAT. The procedures at BAT for employer accounts disputes and claims disputes are the same.

2.6 Medical Dispute Process

The Medical Officers do not contact the injured worker or employer at any time, and do not perform physical exams on the injured worker. There is also very little contact between Medical Officers and the injured worker's treating physician.

SWCB does not have Independent Medical Exams. However, they have 20 external Multidisciplinary Assessment and Rehab Teams (MDA) that are located throughout Saskatchewan. The injured worker's physician or the Case Manager may request assessment by a Multidisciplinary Assessment and Rehab Teams.

In cases where a worker's medical claim has been accepted, but disagreements on their present or future condition/limitations remain between the worker's physician or chiropractor and the Board, then the worker's medical practitioner may request a Medical Review Panel following a decision made by the BAT. A Medical Review Panel (MRP) can only be initiated by the injured worker and the request must be submitted by the worker's physician or chiropractor. The Medical Review Panel is organized by the BAT but is held outside of SWCB. Following the exam and receipt of any test results, the panel members and Chair will create a Certificate of Decision based on their findings. This decision is binding on the SWCB and the injured worker.

2.7 Appeals Advisor Services

The Office of the Workers' Advocate (OWA) provides the Workers' Advocates who are accessible and free of charge to injured workers and their dependents seeking advice regarding claims and/or appeals. OWA Advocates can assist workers by advising on claims and appeals processes, helping a worker prepare for an appeal, or by acting as a representative for the worker at any of the levels of appeal.

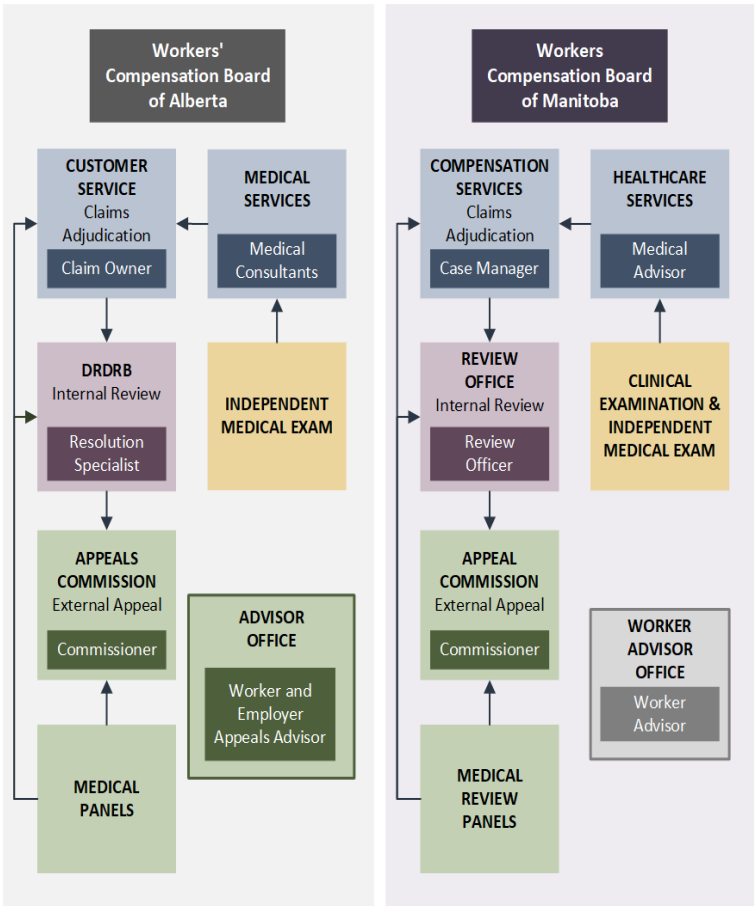
There are no system funded advisors available to employers. SWCB established an Employer Resource Centre (ERC) which supports employers by providing educational material and assistance navigating the SWCB system. They do not represent or advocate on behalf of employers in claims disputes.

3. Workers Compensation Board of Manitoba

3.1 System

Case Managers within the Compensation Services department make decisions on employee injury claims for the Workers Compensation Board of Manitoba. The Case Manager is responsible for acquiring any additional information that is required for them to formulate a decision on a claim.

Case Managers can draw upon independent medical advice from the Medical Advisors that are administered by HCS. Medical opinions may be sought for treatment, recovery, return to work, or entitlement decisions. All Medical Advisors are part time contractors that maintain their own practices in the community in addition to advising on WCB claims.



Quality assurance in claims adjudication is managed by an Operational Manager within the department, while the Director of the Review Office (RO) completes all QA assessments. Trends and statistics are shared between departments.

3.2 Claims Dispute Process

If the worker disagrees with the decision made by the Case Manager, their first step is to contact the Case Manager for clarification on how the decision was made. In the event a dispute cannot be resolved by the Case Manager, a reconsideration may be requested to the RO. There are no time limits for reconsiderations, reviews, or appeals.

3.3 Review Office

The RO is a formal and independent level of review within WCBMB, where senior staff have the authority to alter or overturn decisions made by Case Managers. The RO does not employ Medical Advisors, but when

medical advice is needed, they have access to the same contracted Medical Advisors utilized by Compensation Services (CS) and administered by Health Care Services.

3.4 Appeals Commission

If any party does not agree with the decision made by the Review Officer, they may appeal to the AC. There are no limitations as to what types of decisions may be appealed to the AC. The appeal is either held as an oral hearing where the appellant and participating parties appear before the three-person panel or a file review where panel formulates a decision based upon information in the file and any evidence submitted by the relevant parties.

Decisions made at the AC are final and binding, though there is a potential for a new hearing if certain criteria are met or new and substantial evidence emerges.

3.5 Medical Dispute Process

Unique to Manitoba, Medical Advisors will communicate with and perform in-person examinations of the injured workers if it will support their ability to provide a medical opinion. This has been found to significantly reduce the need for other forms of resolution for medical disputes. By participating in the exam, the worker is given the opportunity to communicate their opinion with the Medical Advisor.

Medical Advisors are also encouraged to communicate with treating practitioners to resolve medical differences of opinion. Their examination notes are shared with the treating physician, increasing transparency, and assisting with the resolution of disputes.

The use of Independent Medical Examiners in WCBMB is rare. Most clinical examinations are conducted by the worker's treating physician or an HCS Medical Advisor. In cases where the appropriate specialist is not available within the Medical Advisor roster, HCS will arrange a non-treating medical examination outside of WCBMB.

In the event the Medical Advisor, IME physician, and worker physician cannot resolve a difference of medical opinion, they or the worker can request a Medical Review Panel. The Medical Review Panel is a three-physician panel. The panel has the authority to examine the worker and send them for further tests. During their exam, the Medical Review Panel will be answering a set of questions posed by the WCBMB or the AC. The worker's treating physician must be invited to attend the Medical Review Panel.

3.6 Appeals Advisor Services

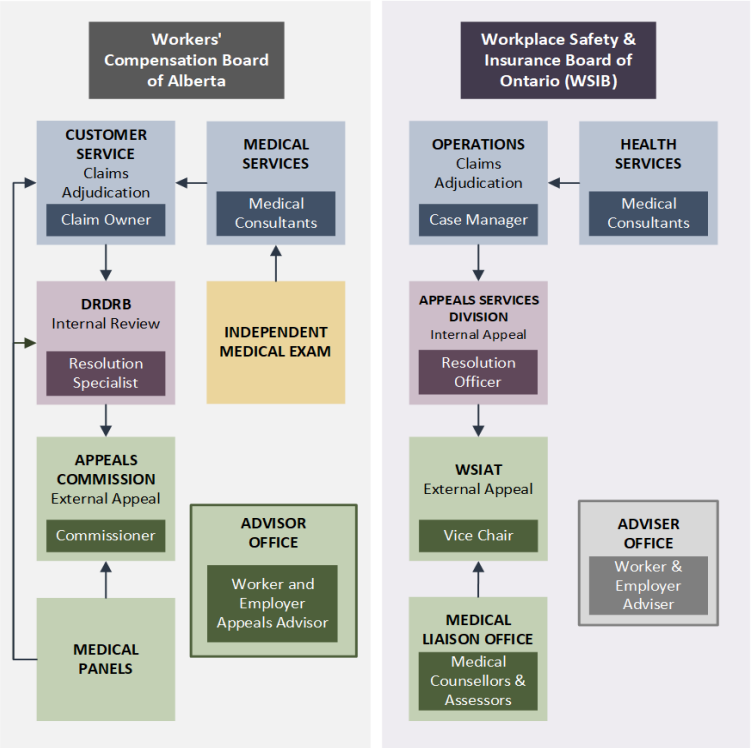
The WAO provides injured workers with free access to advice and representation by Worker Advisors. The Worker Advisors can advise on WCB claims, options, and appeal processes, as well as represent the worker during the appeal. There are no system funded Employer Advisors in Manitoba for representation or advice.

4. Workplace Safety and Insurance Board of Ontario (WSIB)

4.1 System

Case Managers within the Operations Department of WSIB are responsible for adjudicating claims and determining entitlements using a Case Management Framework. Case Managers have access to Medical Consultants to assist with clarifications and to provide medical opinions.

WSIB's Health Services department administers the Medical Consultants that are available to give independent medical opinions to Case Managers. They are all contracted consultants that work from their own practice locations.



4.2 Claims Dispute Process

A claimant will first receive a phone call from the Case Manager explaining the decision-making process, followed by a letter containing the decision on the claim, the rationale for the decision and the applicable policies. If a worker or employer disagrees with a decision, their first step is to contact the Case Manager to further discuss how the decision was made and resolve any misunderstandings. The worker may also request assistance from a Return-to-Work Specialist to help find a solution. If the worker or employer is not satisfied with the decision or explanation from the Case Manager, they can file an "Intent to Object" form or submit a letter of objection to the WSIB. This must be done within 30 days for a return-work-decision or within 6 months for other decisions. The Case Manager will review the objection and reconsider their decision. If the decision remains unchanged, the appellant can submit the Appeal Readiness form, which will move the dispute to the Appeals Services Division.

4.3 Appeals Service Division

The Appeals Services Division (ASD) is a formal level of appeal within WSIB that operates independently from primary claims adjudication and Case Managers. There is no time limit for submitting the Appeal Readiness form once an Intent to Object has been filed. An Appeals Resolution Officer (ARO) is assigned to the file and the Appeals Registrar selects either a hearing in writing or an oral hearing.

If a participating party does not agree with the Appeals Resolution Officer decision, they may submit a request for reconsideration. They have 2 years from the date of the decision to submit the request. If the decision remains unchanged, it can be appealed to the Workplace Safety and Insurance Appeals Tribunal.

4.4 Workplace Safety and Insurance Appeals Tribunal

WSIAT is the final level of appeal for WSIB decisions. All types of worker and employer disputes may be appealed to WSIAT. A worker, employer, or representative can initiate an appeal by submitting a Notice of Appeal to WSIAT. The WSIAT determines the format of the appeal. It can be a hearing in writing (document review) or an oral hearing. WSIAT has its own Medical Liaison Office that provides additional medical information and coordinates additional external medical examinations when required.

4.5 Medical Dispute Process

The Medical Consultants do not contact or examine injured workers. However, they will contact a worker's treating physician to resolve any differences of medical opinions on the file.

WSIB does not have IMEs. In the event there is a need to clarify medical opinions on a worker's claim, or clarify the nature of the injury, the WSIB will arrange an examination that the worker must undergo. Workers may be asked to undergo a medical assessment by an Occupational Health Assessment Program physician, a physician at a speciality clinic, or a Return to Work Specialists at any point throughout the review or appeals process. If a worker has a particularly complex injury, they may be sent directly to a speciality clinic for an assessment in collaboration with the nurse consultant, speciality physician, and the treating physician.

There are no MPs or comparable processes in WSIB or WSIAT. WSIAT's Medical Liaison Office administers Medical Assessors that respond to specific requests made by a WSIAT adjudicator. They provide a medical opinion on the case, and, though it is rarely done, they may also examine the worker. An additional role within the Medical Liaison Office is the Medical Counsellors. During initial screening of cases, those with a medical complexity are referred to a Medical Counsellor. The Medical Counsellor reviews the file and includes additional medical information that can help with the adjudication, such as a WSIAT Medical Discussion Paper or Supplemental Medical Literature. This process ensures the panel has all necessary information available for their decision.

4.6 Appeals Advisor Services

WSIB has both an Office of the Worker Adviser and Office of the Employer Adviser which are system funded. Both offices provide free services to workers and employers, including advice, education, and representation during appeals processes.